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LEGALIZATION OF ILLICIT DRUGS: IMPACT AND FEASIBILITY, PART I

HEARING

BEFORE THE

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

SECOND SESSION

SEPTEMBER 29, 1988

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(100th Congress)

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LEGALIZATION OF ILLICIT DRUGS: IMPACT AND FEASIBILITY

THURSDAY, SEPTEMBER 29, 1988

U.S. House of Representatives,
Select Committee on Narcotics
Abuse and Control,
Washington, DC.

The Committee met, pursuant to call, at 9:30 a.m., in room H210, Cannon House Office Building. The Honorable Charles B. Rangel, Chairman, presiding.

Present: Chairman Charles B. Rangel, Benjamin A. Gilman, Fortney H. (Pete) Stark, James H. Scheuer, Cardiss Collins, Daniel K. Akaka, Frank J. Guarini, Dante B. Fascell, William J. Hughes, Solomon P. Ortiz, Edolphus "Ed" Towns, Lawrence Coughlin, E. Clay Shaw, Jr., Michael G. Oxley, Stan Parris, and Tom Lewis.

Staff present: Edward H. Jurith, Staff Director; Elliott A. Brown, Minority Staff Director; George Gilbert, Staff Counsel; Michael J. Kelley, Staff Counsel; Barbara Stolz, Professional Staff; James Alexander, Professional Staff; Rebecca Hedlund, Professional Staff; Deborah Bodlander, Minority Professional Staff; Richard Baum, Minority Professional Staff; Robert Weiner, Press Officer; Ron Dawson, Corporate Board Intern; and Heide Haberlandt, Staff Assistant.

Chairman Rangel. The Select Committee on Narcotics Abuse and Control will come to order as we begin our hearings on the issues of legalization and decriminalization.

There has been a lot of discussion on this issue on college campuses throughout the country, and on radio and talk shows, especially recently. But this is the very first time that we have brought this important issue to the hallowed halls of the United States Congress.

Most of the people encouraging this type of forum have covered a wide spectrum. They say we should legalize, or some say we should only consider legalization. Other say we should debate legalization, or just discuss it. But, quite frankly, after reading some of the testimony last night and early into the morning, I don't know whether anyone is really advocating legalization.

The reason that we should discuss this, I am told, is because we are losing the war against drugs and that we are focusing on a law enforcement policy that some say is counterproductive.

I think the record is abundantly clear on this. We have hardly declared war against drugs in this country. For people who say that we have focused on a law enforcement policy, two things should be made abundantly clear: that there has been resistance from our government for eight years, in the form of opposition to Congressional attempts to fund local and State law enforcement.

Any mayor, governor, or police chief will tell you that it has not been the policy of this administration to fund local and State law enforcement.

One might ask, "Well, we weren't talking about local and State; we are talking about Federal." How could we possibly say that we have a Federal policy of strict law enforcement when the truth of the matter is that we have less than 3,000 drug enforcement agents in the United States and throughout the world. We merely have 2,800 men and women who are dedicated to fight drugs.

I would think that there are people who say that we should expand in education, expand in rehabilitation, and that is the reason why they would want to consider legalization.

Well, I would say that before they start talking about decriminalization and legalization, should they not say that we have failed to have one Federal rehabilitation program? These are the things that some of us are fighting for, to get our government and our States and our cities involved in sound rehabilitation programs.

Some would say we have to do more in education. Well? They have allowed this administration and this Congress to get away with "Zero Tolerance" slogans, "Just say 'No' " slogans, or "Kick them out of school" slogans.

And, finally, I think if we are giving up on the war, I think we would have to admit that we don't grow opium in this country, we don't grow coca leaves in this country, and we have yet to hear publicly the Secretary of State express his utter contempt for countries and allies and friends that do grow these drugs and poison that come into the United States.

War against drugs? When last have we heard from any Secretary of State indicating that they were prepared to put the military resources to protect our borders against the intrusion of drugs? I submit that this is not the time to be giving up on a war that has just been declared, but has not been effectively waged.

And I am suggesting that those people who would come before this body and want to discuss, debate, open up dialogue as to why we should legalize drugs, should be a little more clear in what they are asking us to consider.

It is not enough to just say that something should be done. If we are going to legislate, what you are asking us to do is to reopen every international treaty that we have had with countries that have agreed not to grow drugs or to declare it illegal.

What we are doing is that we are asking every State to change its laws and we are asking us to take another look at our import and our export balance of trade as we now look to the cocaine-producing countries in Central and South America. Or do we look at our American farmer and give them a chance as we buy American?

We have to be able to discuss this morning and tomorrow what drugs are we talking about, whether they are going to be regulated, because there is an assumption that we are not talking about doing the same that we have for liquor and cigarettes, even though some people say that is an example we should follow.

But I don't believe that people are talking about buying across the counter or vending machines. There has to be regulation. We need guidance as to what they are talking about. We have to make certain that they are not talking about dispensing drugs to kids. We know they don't mean that.

We have to find out what medical research has been done to determine whether or not an addict knows when he has had enough and that the doctors and the hospitals and I assume the professors will determine what enough is. We have to find out whether alcoholics know when they have had enough, whether addicts know when they have enough, or whether they will be going back to the illegal markets.

We have to know what testimony they have from doctors and research organizations as to whether or not there will be an increase in the number of addicts and the children born as addicts.

We have to know whether or not this is a program just for the wealthy that can afford doctors or whether we should insist that it be included in health insurance plans as we are trying to expand coverage.

Are we talking about including this with Medicare? Are we really talking about expanding Medicaid? Are we talking about drug stamps? I don't know. But one thing I do know is that we are talking about let's discuss this, and I assume there are going to be some restrictions as to what they are asking this Congress to consider.

And I would say for those that are involved in public service: It would help the Chair and members of this Committee that, instead of just telling us what has been debated, if you might share with us some of the experiences that you have had and leadership that you have taken in order to see this type of subject matter get a broader audience and to tell us whether or not it has worked.

[Chairman Rangel's opening statement appears on p. 131.]

Chairman RANGEL. At this time I would like to yield to my distinguished Minority senior member, the Republican who serves on this Committee. And I just would like to say that we have never had an issue in the last eight years that has divided along party lines, and this certainly isn't one of them, that we are dedicated to see what we can do to make our country and our society drug-free.

And I yield to the Honorable Benjamin Gilman from the State of New York.

STATEMENT OF THE HONORABLE BENJAMIN A. GILMAN, NEW YORK, U.S. HOUSE OF REPRESENTATIVES, RANKING MINORITY MEMBER, SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

Congressman GILMAN. Thank you, Mr. Chairman. I want to commend you and our staff for arranging an extensive number of panelists today to dig into a very critical and important issue, one that is receiving a great deal of attention and debate throughout our nation today.

We have been describing our struggle against illegal drugs as a "war" against the narcotics people. The drug kingpins are continuing to cash in on our nation's seemingly insatiable appetite for deadly drugs. These multinational criminal syndicates have used their ill-gotten wealth and unrestrained violence to build an evil empire, an empire of breathtaking global magnitude, because we all recognize the narcotics problem isn't just a problem confronting our nation, but today virtually every nation throughout the world.

The drug traffickers' power is so great that they threaten the authority of governments throughout the world. In Latin America we see the situation could be a grave one. Colombia, for example, the home of the Medellin and Cali drug syndicates, is virtually under siege by the drug traffickers. The drug cartels there have been responsible for the assassination of the Colombian Minister of Justice, an Attorney General, more than 50 judges of the highest courts in that land, virtually placing the whole court in a state of not being able to act in any manner, at least a dozen journalists have been killed and several publishers, and more than 400 police killed in the last few years in attempting to bring law and order to that country. Thousands of courageous Colombians continue to work under President Barco's leadership to combat narcotics in spite of death threats to themselves and to their families.

And when the narco-traffickers offered to negotiate with the Colombian government, promising to help pay off the national debt if they were to be granted amnesty, the Colombian people didn't seek the moral low-ground occupied by the drug traffickers. They resisted the financial temptation of easing their own burdens. And they rejected these kind of offers and didn't surrender to the drug kingpins.

And now here in our own nation some are calling for that kind of a surrender, to wave the white flag to the drug traffickers. They argue, "It is time that we compromise some of these morals and values and the lives of thousands of citizens by legalization." They advise our policy-makers to give up the moral high ground. And they say, "Come on. It is time to make a deal with these people." They contend that legalizing drugs will end the drug crisis. I think that is virtually akin to ending violent crime by legalizing those very crimes.

Drug legalization is not going to put the international cartels out of business. Prohibition did not end organized crime. The cartels will adapt. They will find new ways to penetrate the United States market, to continue their business operations in both the European continent and in Asia and perhaps move more extensively into gunrunning and terrorism. Drug trafficking and drug abuse is not a problem that is going to be solved with the stroke of a pen or by statutory legalization.

And neither will drug legalization end drug-related street crime. In an A.B.C. News poll this month, 76 percent of Americans said legalization would not decrease crime. The reason they say this is that they have seen the addicts on their streets and they understand that drug users don't steal, rape and murder only because they need money to pay for their habit. They also break the law because their judgment, stability and state of mind are eroded by their drug use. I am wondering if anyone really thinks that, under legalization, the drug addict is going to be able to go into a 24-hour-a-day drug supermarket, pick up a legal dosage, and then stay out of trouble? I would hope that our panelists could answer some of those problems.

However, despite my feelings about legalization, it doesn't follow that I believe that our drug policy has been truly effective in reducing the supply and the demand of drugs. And many of those who advocate legalization credibly criticize our past inadequacies in our war against drugs. So today we do have an opportunity to focus our nation's attention on this deadly problem and to try to find some new solutions.

And we look forward to the testimony by our panelists, our colleagues who have been willing to come forward, and some of the specialists who are out there on the battlefield daily confronting this problem. We hope that out of these hearings will come some fresh new ideas that our nation can adopt so that we will be more effective in what we are seeking to do.

Thank you, Mr. Chairman.

[Statement of Congressman Gilman appears on p. 140.]

Chairman RANGEL. Mr. Stark of California?

STATEMENT OF THE HONORABLE FORTNEY H. (PETE) STARK, CALIFORNIA, U.S. HOUSE OF REPRESENTATIVES, MEMBER, SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

Congressman STARK. Mr. Chairman, I want to commend you for holding these hearings. Your leadership in fighting drugs makes you a hero in the overall war on drugs.

Mr. Chairman, our cities, New York and Oakland, have been heavily affected by the drug plague. Our districts, neighborhood are the free fire zone on the war on drugs.

New York and Oakland share common drug-related characteristics. Both cities are able to treat only 10 percent of the cocaine and heroin addicts seeking treatment. Both cities require addicts to wait at least six months for treatment. Both cities have seen drug-related crime rates skyrocket as a result of the lack of available treatment. Both cities spend many times more funds and resources arresting users than concentrating on treating the addicted.

Legalization of illegal narcotics is not the answer. We must treat the abuser so the residents of New York and Oakland will be safer in the future. Every time we turn away an addict, we are unwitting and unwilling accomplices to crimes committed in order to maintain an expensive habit.

Mr. Chairman, as one approach, I am introducing a bill to provide treatment for all addicts seeking help. Treatment on request, I think, is a good answer to lowering our cities' drug-related crime rate.

My bill will be financed through the social security program's disability insurance provisions and use a Medicare-type payment principle to provide a full range of cost-controlled inpatient and outpatient rehabilitation services. Simply put, treatment on request ought to be part of our crime reduction program.

I welcome the opportunity to hear today's witness. It is important that we begin to add emphasis to the health-oriented solutions and other humane approaches.

Thank you.

Chairman Rangel. Thank you.

[Statement of Congressman Stark appears on p. 143.]

Chairman Rangel. Mr. Oxley from Ohio?

STATEMENT OF THE HONORABLE MICHAEL G. OXLEY, OHIO, U.S. HOUSE OF REPRESENTATIVES, MEMBER, SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

Congressman Oxley. Thank you, Mr. Chairman. First I would like to commend you for your countless writing, interviews and statements opposing the concept that is before this Committee today.

I will be brief in my opening statement, but I feel very strongly that several points need to be made about this hearing. I want to say it is my studied opinion that we shouldn't even dignify the idea of legalizing drugs with a two-day hearing. It seems to me that this is entirely contrary to the jurisdiction and to the mission of this Committee.

I find it difficult to believe, and even harder to accept, that we are spending Congressional time on this notion of legalizing drugs. Congressional time is precious. It is expensive to the taxpayers and particularly so as we reach the end of the historic 100th Congress.

In addition, we have assembled a long list of witnesses with extensive backgrounds and distinguished educations. And it seems to me that we could channel their talents and their time more constructively to try to do something positive about the problem rather than having the focus of this day and tomorrow on the legalization of drugs.

Why are we even considering this dangerous and disastrous idea? Is this the message we want to send to the nation and to the world from the United States Congress? Is this what we want to say to the family of Enrique Camarena? Is this what we have to say to the Colombian drug cartels, the narco-terrorists, the organized crime mobs that traffic drugs?

Just as importantly, is this what we say about innocent citizens who have been murdered and maimed by violence caused by P.C.P.? What about the thousands upon thousands of Americans who have been robbed by drug addicts supporting their habits?

Is this what we say to America's teenagers, who are trying to decide whether or not to experiment with dangerous drugs, that we are contemplating, after all of this public effort and money already invested in the war, after all of the personal grief and failure caused by drugs, "Well, we changed our minds. Drugs are really okay, after all"? I don't want to be any part of that message. This is no solution. This would be chaos that, to me, is completely unacceptable for this civilized country.

To take the logic to its extreme, crime could be completely eliminated from our society by deciding that the government no longer opposes murder, assault, and all other behavior now deemed criminal.

Mr. Chairman, we know the effects of the underground black market drug economy. We know that it zaps more than $140 billion each year from our national wealth. We know the direct relationship of individuals to organized crime to problems in schools and truancy and youth, suicides, shootings, robberies, murders, traffic fatalities, addicted babies, the spread of A.I.D.S., and countless other public policy difficulties and personal tragedies.

One of the unique qualities about this country is that we are fighters. Whether you want to call it the "pioneer spirit," the "can-do spirit," or the "work ethic," we have always tried to take decisive actions about things that are wrong in this country and throughout the world.

I certainly hope that this hearing is not an indication that we are just going to "roll over and play dead" on the drug issue. This is far worse than no response at all. My best hope for an outcome of today's Committee session is that we close this totally unproductive chapter on the debate once and for all.

And I thank the Chair for his indulgence.

Chairman RANGEL. Thank you, Mr. Oxley.

Mr. Guarini, a member of the Ways and Means Committee has worked very hard on this issue domestically as well as in foreign affairs.

STATEMENT OF THE HONORABLE FRANK J. GUARINI, NEW JERSEY, U.S. HOUSE OF REPRESENTATIVES, MEMBER, SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

Congressman GUARINI. Thank you very much, Mr. Chairman. I am very pleased that outstanding, distinguished panelists are here today to discuss the issue of legalization of drugs. Mr. Chairman, I want to thank you for your deep sensitivity to this problem and to the national direction that you have given Congress and our nation. It is an important issue. Thoughtful discussion deserves the national interest.

I do not support legalization as a cure to our nation's drug problem. I believe it is the wrong policy and sends the wrong signal. It sends the wrong signal to the drug lords that we have lost and they have won. It sends the wrong signal to our kids that the United States Government is saying "yes" to drugs.

Mr. Chairman, during the presidential campaign, Jesse Jackson said, "Up with hope; down with dope." I think he made a very important point. Instead of making drugs legal, we should motivate people so they don't need drugs, so that the young people don't use drugs. I think that is where the issue lies.

We need to do more for the people and children of America to give them something to believe in, something to work for, something tc fight for. We need to renew that sense of purpose, that spirit of idealism, that American notion of decency and compassion that every child should grow up with hope, not hunger, every child should live by dreams and not despair. We need to heal wounds and unite families.

We need to renew respect for laws and define "law" as promoting justice. We need books and learning and a power of knowledge. We need a world where every child can wake up in the morning and say, "I can use my talents. I can accomplish great things. I can really be somebody. And nothing, nothing in the world can stop me."

No, I don't think we need to make drugs available to all of the young people of America. We need to give people an alternative to drugs. We need hope. We need opportunity. We need inspiration and leadership.

I look forward to the hearing today because I do think that there should be a national dialogue on this issue. And I think that it will make a very important contribution to the drug issue and perhaps in the long run to erasing the scourge that we have facing our nation.

Thank you, Mr. Chairman.

Chairman RANGEL. Thank you.

Mr. Lewis of Florida?

STATEMENT OF THE HONORABLE TOM LEWIS, FLORIDA, U.S. HOUSE OF REPRESENTATIVES, MEMBER, SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

Congressman LEWIS. Thank you, Mr. Chairman, and I thank you for the opportunity to speak on this crucial issue.

Frankly, it seems contradictory to me that those of us who have committed ourselves to the fight against drugs have agreed to hold a hearing on giving in to drugs. Legalization is a surrender, and we must not and cannot surrender when future generations are at stake. That is, in essence, what we are doing when we talk of legalizing drugs.

We cannot ask our children to say "No" to the ravages of drugs, warning them to the physical and the emotional trauma involved, and then give up on our part of the fight. There is no way to justify the untold destruction of minds and bodies that would result from the legalization of drugs.

Making drugs more affordable and more readily available cannot be anything but detrimental to our society. I particularly object to those who advocate legalization on the grounds that the Government can ultimately make a profit on the drug trade for itself.

Legitimizing drug profits and turning the Government and private citizens into drug traffickers is an appalling notion that should be rejected by this Committee without hesitation. Legalizing drugs will not rid us of this problem; it will only exacerbate it. We cannot make that very grave mistake.

And I look forward to hearing the testimony of some of the leaders of our society and communities who want to come before this Committee to make statements on legalizing drugs, and I would like to hear what they have to say to many of the questions that will be asked by this Committee.

Thank you, Mr. Chairman.

Chairman RANGEL. I might take this opportunity, and I am confident that you can hear me in the back, to share with you that, because of the overwhelming number of people who have asked to testify and be heard, we are going to have to rotate the spectators after the panels, because we have a large number of people waiting in the hallways.

Also, I will be reminding the press and spectators that we will break from 12:30 to 1:30 and resume the hearings at 1:30. We also, as most of you know, because of the large number of people who wanted to testify, extended the hearing into tomorrow.

Well, I know that we have a distinguished panel of members of Congress, which includes the Chairman of the Foreign Affairs Committee, and we have any number of members here. Then I will ask the members of the Committee whether they would speak loudly and hope that we can plug into this.

Mr. Ortiz of Texas?

STATEMENT OF THE HONORABLE SOLOMON P. ORTIZ, TEXAS, U.S. HOUSE OF REPRESENTATIVES, MEMBER, SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

Congressman ORTIZ. Thank you, Mr. Chairman. In the interest of time, I will be as brief as possible, but let me take this opportunity to welcome the outstanding members of Congress and other members who will be witnesses this morning.

Before becoming a Congressman, I served as a law enforcement official as a sheriff in south Texas. As such, I saw many brave and dedicated men and women sacrifice their time, their effort, and often their lives in fighting what we call the "war" on drugs.

Why would someone lay down their life for this purpose? Certainly a sense of duty to enforce the law of the land is a primary motivation, but there is more to it than that. Those who so bravely wage this war also know what illegal drugs are doing to our children, to our communities, and our nation as a whole.

These drugs take away the God-given gift of human potential. They poison and destroy the body, the mind, and the soul. When even one more citizen falls prey to the addiction of these substances, we all suffer as a society.

Legalization will not change this. The war on drugs is not just about money or the economics of a black market. It is also about human potential and our potential as a people.

I recognize the position of those who feel that we must openly debate this topic. That is why we are so engaged in this hearing today. But it is a tragic comment on the effect that illegal drugs have had on this country when reasonable persons are driven to seriously consider unreasonable proposals.

And I remain convinced that when all is said and done, we will realize the tragically misguided nature of admitting defeat in a war we have barely begun to wage.

Thank you, Mr. Chairman.

[Statement of Congressman Ortiz appears on p. 145.]

Chairman RANGEL. Mr. Hughes of New Jersey, and the Chairman of the Crime Committee of the Judiciary Committee that has made a substantial contribution to our bill in this Committee?

STATEMENT OF THE HONORABLE WILLIAM J. HUGHES, NEW JERSEY, U.S. HOUSE OF REPRESENTATIVES, MEMBER, SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

Congressman HUGHES. Thank you, Mr. Chairman. I want to congratulate you on convening this hearing.

Unlike some of our colleagues, this is a democracy, and we should never fear the debate and discussion of ideas, although they might be held by a very small portion of our population. So I want to welcome our distinguished panel of colleagues from the Congress and the distinguished panels that follow.

Let me just say at the outset that I am very much opposed to the legalization of drugs. I haven't come by that without a lot of reflection over the years. I am in my 24th year in law enforcement in one way or another: 10 years as a prosecutor, 14 years in Congress, working in the criminal justice system.

And I respect those that believe that legalization perhaps is something we should consider. They are just dead wrong. First, I would like to hear from the witnesses that follow just where in anywhere in the world they can point to where legalization has ever worked. Show us where it has worked.

Secondly, those that suggest that we take the profits out of drugs by legalization, I would like for them to suggest how that is going to occur. We are not going to eliminate the black market. And those that believe that we are not going to exacerbate the problems that we already have in our health care area should point to how, in fact, we are going to solve our problems by legalizing drugs. We are up to our eyeballs in contraband of all kinds.

The policies that we have developed over the years can work if we, in fact, make the commitments that are needed to make them work. We haven't done that yet. We have not committed the resources, and we have not made the commitments as a society that we need. We don't have as much substance abuse in America as we will tolerate.

We have a good strategy. The omnibus bill that we just passed has many provisions; while controversial, I think, advances in the right direction. Now we must take it the next step and make the commitments internationally and domestically that are needed to deal with the problem both on the demand reduction side, which is where I would spend most of the money, as well as the interdiction side. When we get serious about the problem, we will begin to turn the corner.

Thank you, Mr. Chairman.

Chairman Rangel. Thank you, Mr. Hughes.

Mr. Larry Coughlin of Pennsylvania?

STATEMENT OF THE HONORABLE LAWRENCE COUGHLIN, PENNSYLVANIA, U.S. HOUSE OF REPRESENTATIVES, MEMBER, SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

Congressman Coughlin. Thank you, Mr. Chairman.

I join other members of the Committee who are concerned that perhaps the fact that we are even holding a hearing on legalization could suggest to young people that the use of drugs is all right. I also worry that a discussion of legalization could be interpreted as a cop-out in the battle against drugs.

Therefore, I hope no one interprets the occurrence of these hearings as saying that we are suggesting to young people that the use of drugs may be acceptable.

I would like to call your attention to a quote from a recent article by the Attorney General of Pennsylvania, Leroy Zimmerman, on the subject of legalization—"In Philadelphia, over 50 percent of the child abuse fatalities involve parents who heavily use cocaine. Cheaper, legal cocaine would result in more children dying and more babies being born addicted."

Statements of this nature by the Attorney General of Pennsylvania, among others, reinforces the grave concerns I have about the implications of these hearings.

And I thank the Chairman.

Chairman RANGEL. Thank you.

Ms. Collins of Illinois?

STATEMENT OF THE HONORABLE CARDISS COLLINS, ILLINOIS, U.S. HOUSE OF REPRESENTATIVES, MEMBER, SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

Congresswoman COLLINS. Thank you, Mr. Chairman. I want to commend you for holding this hearing, Mr. Chairman. I think the question of whether there should or should not be legalization of drugs is not only a timely subject, but one that is uppermost on everybody's mind.

In my own personal view, I think that legalization is not only a gamble, but a long-range gamble. Where drug-related violence and criminality could conceivably decrease over a short period of time, I am inclined to believe that this is not a permanent solution.

So I welcome the witnesses who will be appearing before us today and tomorrow and hope that their testimony will shed some new light on this subject, if, in fact, there is any new light to be shed, so that we can all come to a final decision on whether legalization of drugs should occur and yield back the balance of my time, and ask unanimous consent to have my full statement made a part of the record.

Chairman RANGEL. Without objection.

[Statement of Congresswoman Collins appears on p. 150.]

Chairman RANGEL. Mr. Akaka of Hawaii?

STATEMENT OF THE HONORABLE DANIEL K. AKAKA, HAWAII, U.S. HOUSE OF REPRESENTATIVES, MEMBER, SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

Congressman AKAKA. Thank you very much. Mr. Chairman, I am pleased that you have presented this forum today whereby arguments on both sides of the aisle can be heard on the proposal to legalize drugs. I also want to say that you have been an able and compassionate Chairman in combatting our Nation's drug problem, and you are to be commended for your leadership.

I would like to welcome also our witnesses today and to thank you for your preparation and time. The very mention of the word "legalization" stirs up an emotion in many of us, and it is important that we have this opportunity to voice and listen to all arguments.

The issue today is not to sanction the use of drugs, but to question whether legalization can break the stranglehold that drugs have on our community or if it would serve as the impetus that suffocates our society. The pervasion of our drug problem is past alarming; it is deadly.

We have long contended that drugs affect all of us, not just the user and the pusher, and never has this been more apparent than today as we read the daily news. Our homes are being broken into by addicts looking for fast cash, innocent bystanders are shot at in drug feuds, minors lured by cash are being killed in turf wars, and passengers have been killed because of drug-impaired operators.

Personally, I am opposed to legalization. Nevertheless, if a viable solution, Mr. Chairman, can be recommended, I am willing to listen. I look forward to hearing from all witnesses today. I yield back the balance of my time and ask that my full statement be placed in the record.

Chairman **Rangel**. Without objection.

[Statement of Congressman Akaka appears on p. 155.]

Chairman **Rangel**. I would like to announce that we have a very distinguished panel of members of the United States Congress: Mr. James Scheuer of New York, who is a member of this Committee; the Honorable Dante Fascell of Florida, who is Chairman of the Foreign Affairs Committee and a member of this Committee; the Honorable Carroll Hubbard, Jr. from Kentucky; the Honorable Benjamin Cardin of Maryland; and the Honorable Kweisi Mfume of Maryland.

Let us start off by asking——

Congressman **Dyson**. You forgot one, Mr. Chairman.

Chairman **Rangel**. I'm sorry. Roy Dyson of Maryland, who was here earlier, who has been working very closely with the Congress and with this Committee as well.

I would like at this time to recognize the Chairman of the distinguished Foreign Affairs Committee, and congratulate him on the efforts that he has made in providing leadership not only on the Foreign Affairs Committee, but certainly in the House of Representatives, in recognizing how many democracies, fragile though they may be, that have become dependent on these crops and are not just saying "No," but are trying to work out comprehensive programs where these people can survive economically, where these democracies can be preserved, where we can move with eradication and at the same time supply substitute crops so these people can survive.

Some of the ideas that you and your Committee have come up with certainly have been supported not only by the members who serve on Foreign Affairs, or on the Select Committee, but by the House of Representatives.

I want to thank you for bringing the prestige of your Committee and your office to open up this panel of members.

Mr. Fascell?

STATEMENT OF THE HONORABLE DANTE B. FASCELL, FLORIDA, U.S. HOUSE OF REPRESENTATIVES, MEMBER, SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

Congressman **Fascell**. Mr. Chairman, my colleagues, I am delighted to have the opportunity to be here and to say that our Task Force on Narcotics in the Foreign Affairs Committee has had the privilege of working very closely with you and our colleagues on this Select Committee in forging legislation, taking initiatives and dealing with the problem of narcotics in this country.

Let me say at the outset, with regard to these hearings, I am against legalization, decriminalization, or whatever word we want to use with respect to the problem. Nevertheless, I think that it is useful to have the hearings and have the debate because I think the rationalization of legalization has to either be sustained or exploded, if not understood, at this point.

We know because of our past efforts that legislation in and of itself is not an answer. It is a frustrated hope in trying to deal with the problem. For example, if we were 100 percent successful in interdiction overseas so that there was no overseas supply, I guarantee you it wouldn't take 10 minutes to load the streets of the United States with drugs of equal potency at a cheaper price, and we wouldn't have solved the problem at all. It is a frustrating, maddening problem.

I don't think legalization is the answer, however. I can see it now: dispensaries on every corner. Do you let them in the hospitals? Do you have them around schools? Do you have them around churches? Or do you have special dispensaries?

This is not a new problem, you know. In the early days of this country, liquid opium was available. In other countries, lime houses existed. Should we now re-open them painted with white and green stripes so that they would be easily identifiable? Marijuana dispensaries would be a green pastel. Opium houses or dispensaries would be painted pink with black dots. Or you would have a multi-colored dispensary so that you would get whatever you would want when you walked in there.

But how does free availability deal with the demand problem that afflicts this country? Reduction of demand is a worldwide problem. Free feeding of the demand might keep people out of jail and might take the profit out of narcotic selling—but?

I notice you have distinguished panelists here. If the scientists can't tell us how to deal with this problem, how do we think we are going to legislate motivation or reduction in demand? That is the key issue, it seems to me.

I have a funny feeling about this question of legalization. I don't know whether this is a correct comparison, but it is kind of like putting gasoline on a fire to put it out or giving alcoholics free whiskey wherever they want.

And then what are we going to do to keep drug addicts off the streets? Do you want a whole bunch of people just lying around wrapping rubber tubings on their forearms or legs and sticking themselves with a needle out in public? Maybe you will have to give them dens.

Are we talking about mandatory treatment, incarceration as some kind of a rehabilitative program? Are we talking about halfway houses, some of which have been successful?

You know, there are a lot of problems with this simple concept of simply saying "Take the money out of this business, and you will solve the problem," or "it will be a big step towards solving the problem." That remains to be seen for me. I just don't see that. The rationale doesn't add up.

And so I start out very strongly against the legislative process which would legalize drugs in an effort to change our society.

I thank you, Mr. Chairman. I have a prepared statement, which I have asked permission to submit for the record.

Chairman **Rangel**. Mr. Chairman, your statement, your full statement, will be entered into the record without objection.

[Statement of Congressman Fascell appears on p. 156.]

Chairman **Rangel**. The next speaker perhaps will answer some of the serious questions that you raised. Jim Scheuer is the Dean of our New York City Delegation. He has been a member of the Select Committee on Narcotics since its inception, and even before that he has been a vigorous fighter against the abuse of drugs and an advocate of education and rehabilitation. He is an author. He is my friend. And I think I disagree with him.

Mr. Scheuer?

TESTIMONY OF THE HONORABLE JAMES H. SCHEUER, NEW YORK, U.S. HOUSE OF REPRESENTATIVES, MEMBER, SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

Congressman **Scheuer**. Thank you, Charlie. It is true, and I am proud of the fact that it is true, you and I have been friends since 1969, longer than the time you have served in Congress and almost as long as I have served.

And there is no member of Congress for whom I have more respect, who is more determined to make progress in this agonizingly difficult area than you are. And I take my hat off to you for the remarkable, outstanding leadership that you have shown over the years as Chairman of this Committee and in calling this hearing.

And I profoundly hope that you will continue this leadership by continuing the hearings because, Mr. Chairman, I would say symbolically, in answer to your question that you think I have some answers, I don't have answers.

But I have got a lot of questions, a lot of questions that need to be answered, and they are not all going to be answered in this hearing. We are going to have to have a lot of hearings with law enforcement professionals, with sociologists, with health people who can tell us about rehabilitation and detoxification, and with education experts.

The questions are daunting, but we have got to put our minds and our hearts to answering these questions because the ultimate cop-out, Mr. Chairman, the ultimate admission of defeat, and I have heard these phrases from several of my colleagues this morning, would be to do nothing, would be to sit with a transparently failed system and simply crank more resources into it, more resources into the sinkhole that is our present system of controlling drugs.

Now, it is quite true over the years that drug arrests have picked up, drug seizures of equipment and vehicles have picked up, seizures of narcotics have picked up. And if all you are going to look at and if all we are going to preen ourselves about in the law enforcement community is the increase, in some cases spectacular increases, in the drug seizures, equipment, and materials, and vehicle seizures, arrests, convictions of drug pushers, well, then, we have done a wonderful job, a remarkable job in our society, and we have succeeded.

But, Mr. Chairman, if you look at what is happening in our neighborhoods, if you look at the rate of addiction among our kids, if you look at the crimogenic impact of drugs on our society and the virtual—I won't say virtual destruction of urban society, but of the poisoning of large parts of our urban society, then you have to come to the conclusion that we have failed.

Now we have an old adage in our country, "If it ain't broke, don't fix it." But the corollary to that, Mr. Chairman, is: If it is broke, then you bloody well try and analyze the problem, figure out what is wrong, and build a new system that will work, and that means fixing it.

We have a failed system in our country, totally failed. Seizures, arrests, convictions, going up, yes, and violence and rates of addiction and increases in a drug like crack, the most poisonous drug of them all, also going up.

How can we preen ourselves in the accomplishment of the former when the latter is really the ball game? What is happening in the neighborhoods? What is happening to a whole generation of kids, particularly minority kids, particularly ghetto kids; not exclusively, but certainly drug abuse has had a devastating impact on those communities?

I think we have to have the intellectual honesty and the guts and the courage to say, "All is not well. We have a failed system, and by golly, we ought to do something about it."

Now one thing that we have to do about it is something that you and I and most members of this Committee have been calling for for years, and that is an end to the preoccupation with the criminal justice side of the thing, the supply side, and far more preoccupation with behavior, with treatment and, above all, drug education.

And you have been at the forefront of those who have called for more drug education and more treatment and more rehabilitation and more significant efforts to change behavior of our young kids.

And it can be done; we know we can change behavior. We have changed behavior in this country on alcoholism. There is now a lower level of drunk-driving arrests.

Diet: We have radically changed our diet, reduction of fats and so forth. If you don't believe me, ask the dairy industry, ask the cheese industry, ask the meat industry. We have undergone profound changes in diet.

We are exercising all over the place. Americans are jogging. That is a positive change in behavior.

And there has been a reduction in tobacco consumption by every single group in our society but young teenage girls. We know we can change behavior. This is the challenge.

Mr. Chairman, this problem may be too tough for our Committee to handle and for our Congress to handle. A number of years ago we had a problem in refiguring our Social Security system, and we called upon a commission to do it, to give us a little protection, a little political protection. And they did it, and they came up with a fine program, and this Congress passed it.

And just a few months ago—we created another presidential commission on bringing some kind of equilibrium into Government income and Government spending. We don't even want to talk about taxes; we talk about revenue enhancement.

That is an issue that has been too hot for us to handle in this Congress this year and in prior years, especially this year. So we set up a commission, chaired by two prestigious, brilliant, and forceful Americans: Drew Lewis and Bob Sprause. And they are going to report to us after the election.

Maybe that is what we have to do in this field of drugs, to look at all of the options, because there are profoundly important questions that we have to ask ourselves. And you asked a number of them. Every one of those questions that you asked are good questions.

My colleague, Danny Fascell, Chairman of the Foreign Affairs Committee, is as brilliant and distinguished a member of Congress as we have. He asked a number of questions. And there are several more questions.

How can we reduce demand for illicit drugs? How do we work on the demand side? What does it take to get the change in behavior on the powerful surge of demands for drugs among our young people? How do we effect the change that we have done in alcohol, tobacco, diet, and so forth?

So that is the question: How do we reduce the demand for illicit drugs? Which treatment programs are most effective in keeping drug addicts from committing crimes? What are the costs and benefits of massive police crackdowns on drug-dealing locations?

Now, these aren't even my questions. These are questions that 50 law enforcement professionals asked America two months ago, in July. Now, law enforcement professionals all over the country, Mr. Chairman, have been telling this Committee for several years now that we have got to look at the demand end of the quotient; we have got to look at the demand side. We can't rely on law enforcement to do it.

Colonel Ralph Milstead testified two or three years ago when we were in Arizona, and we saw law enforcement officials all along our border. And he testified that, "By golly, law enforcement can't do it. You have a snake. And the first thing you have got to do is cut that snake's head off." Cut it off. That is demand.

So that is the challenge. I'm not going to use the "L" word. I'm not going to use the "D" word. All I am going to say is we have to address ourselves to these questions. We have to look across the broad spectrum of options to this pitifully failed system, this bloody sinkhole that we are pouring money into.

And while arrests and convictions and seizures of all kinds of things, supplies, equipment, vehicles, drugs, soar into the stratosphere, also drug consumption in our neighborhoods is soaring into the stratosphere. That is a failed system.

And I repeat: the ultimate cop-out, the ultimate omission of defeat would be for us to do nothing and continue to pour money down that bloody sinkhole.

Mr. Chairman?

Chairman Rangel. Yes?

Congressman **Scheuer**. I don't want to take up any more time of this Committee. I know you have got a long list of witnesses. I hope that this Committee has the guts and the intelligence—and I know it does—to consider this not the end, but the beginning. This is a wonderful beginning. You have posed terribly important questions; Danny has; others have. The police officials that I've—50 police chiefs have.

Why don't we get down to it and perhaps early next year have a well-structured set of hearings that will be nonpolitical, that will be bipartisan, and that will be intelligent and carefully thought through, bringing in all of the experts from all over the country to answer the questions that you have been posing?

I can't answer them, Mr. Chairman. I don't think any member of this panel can answer them. But we owe it to ourselves to get the answers. We owe it to ourselves to end this absurd situation where we are spending two and a half times more in a failed law enforcement program than we are spending on transparently urgently needed programs of education to train kids, to treat kids.

Kids have to wait six months to a year to get into a drug program, the very kids who are out there committing the two-thirds or three-quarters of the urban crime that is a result of drug addiction. And when those kids decide they want help, they want to get the monkey off their backs, we tell them, "Well, come back next year." That is absurd. That isn't America.

We have a hell of a big job to do, Mr. Chairman. You could be a noble and marvelous leader of this Committee and this Congress and the American people in leading us to a searching scrutiny of all of the questions that have to be answered. I beg you and I urge you to do it.

Kurt Schmoke's name has been mentioned. He is a brilliant guy. He isn't a Rhodes scholar for nothing. He has an important message for us. He and probably most of our other witnesses don't have the ultimate answers, but we can find the ultimate answers.

Chairman **Rangel**. He will be testifying, Mr. Scheuer.

Congressman **Scheuer**. I beg your pardon?

Chairman **Rangel**. He will be a witness.

Congressman **Scheuer**. Yes, I know he will.

Chairman **Rangel**. Oh, I didn't know you knew.

Congressman **Scheuer**. I ask us all to listen to these other witnesses with an open mind, and then let's set us to the task of finding alternative options to this pitifully tragically failed system into which we are pouring billions and billions of dollars today with nary an impact on the flagrant and historic heights of drug addiction going on in our neighborhoods.

The time is now, Mr. Chairman.

Chairman **Rangel**. Thank you.

Congressman **Scheuer**. In urban America, the time is right now.

Chairman **Rangel**. Thank you very much.

Congressman **Scheuer**. Thank you.

Chairman **Rangel**. And you can depend on this Committee asking the questions today and tomorrow. And I assume you are saying that you do believe that the question of legalization and decriminalization should be on the table for discussion?

Congressman **Scheuer**. I think we ought to look into every aspect of the "D" word and the "L" word.

Chairman **Rangel**. I just wanted to make certain that we got the record straight.

Congressman **Scheuer**. And I am not going to pass the barrier today, but we ought to look into a host of other questions, too——

Chairman **Rangel**. Exactly. I just wanted to——

Congressman **Scheuer** [continuing]. As to what the viable, logical, thoughtful alternatives should be——

Chairman **Rangel**. I just wanted for the record to understand——

Congressman **Scheuer** [continuing]. For a totally failed policy.

Chairman **Rangel** [continuing]. Whether or not the "L" and the "D" words were understood for the record, that that is legalization of drugs and decriminalization of drugs.

I would like at this time to recognize the distinguished gentleman from Kentucky, Carroll Hubbard, Jr.

TESTIMONY OF THE HONORABLE CARROLL HUBBARD, JR., KENTUCKY, U.S. HOUSE OF REPRESENTATIVES

Congressman **Hubbard**. Thank you very much, Mr. Chairman. I do appreciate the privilege of testifying on this important subject today. I appreciate the work of Chairman Charlie Rangel and the members of this distinguished panel toward this problem.

The last two speakers are from Miami and New York City. The previous speaker said, "In urban America, the time is now for action." Maybe it is timely that I am the next speaker, because I do represent 550,000 people in a very rural part of America, in western Kentucky, an area beginning on the Mississippi River and going east about 185 miles toward Louisville. Indeed, in rural America, the time is now for action.

Yes, we are thinking of drug problems in Washington, D.C. or New York or Miami or Chicago, but I can assure you that even in a rural area like mine, where we are thought to be in the Bible Belt and with churches more prominent than grocery stores, the drug problem is acute; the drug problem is serious.

In fact, in my own Congressional District, it is so serious that the Customs Service is aware of the drug problem in western Kentucky. They are aware, as is the Drug Enforcement Administration, that flights are coming into our rural area, into the most rural of airports, from Colombia and Mexico, flying in processed marijuana and cocaine into a rural area like western Kentucky, which is safer now for flights for the drug dealers than it is to fly into New Orleans or Miami, Palm Beach, or some of the areas where the F.B.I., the D.E.A., and Customs Service agents are plentiful.

Should we be having this hearing? Well, I share the thoughts of Congressman Larry Coughlin, who is concerned that as we have this hearing, some may think, "Well, this is debatable: Should it be legal or not?" Well, of course, that is the subject of our hearing, and it is becoming more and more debatable, unfortunately.

The Nashville, Tennessean, a respected newspaper which is read in my Congressional District, has endorsed legalization of drugs.

We heard this subject discussed at length the other night on A.B.C. Nightline, and there were proponents and opponents of this particular subject.

But I would hope that Members of Congress realize that yes, there is a problem as to the desire for drugs and demand for drugs in this, the greatest country on earth. Unfortunately, more cocaine and illegal drugs are consumed in the United States of America than any other country in the world.

As Congressman Scheuer said, why is this that we have such a desire and a demand for drugs in our society today? But I would hope that we, as Members of Congress, would continue to try to lead our constituents and, indeed, the 100 members of the Senate and the 435 members of the House and work hard to see to it that we never legalize the sale of drugs in this, the greatest country on earth.

I can assure you that even in a rural area like mine, the drug dealers are serious. And as we listen to those witnesses such as the Mayor of Baltimore and others propose that we have legalization of drugs, I would hope that they realize that this would, unfortunately, cause more people to try and experiment with drugs.

I know for sure that the drug dealers are serious about wanting to sell more and more drugs. Tragically, they have even invaded rural schools such as I have in the district I represent in western Kentucky.

There was a grand jury hearing in Warren County, Kentucky, last December. Much publicity was given to it. This Member of Congress testified before that Warren County grand jury in Bowling Green, Kentucky.

Shortly thereafter, the F.B.I. was aware that there were some death threats upon this Member of Congress because I had the gall to go before a grand jury and name a few names there in Bowling Green of people who were selling drugs to students at Western Kentucky University. The first call I received this year on January 1 was from the Capitol Hill Police to inform my wife and me of these threats by drug dealers in western Kentucky.

Yes, I mention this because, as we hear from urban America, New York City, Los Angeles, and the others, be assured that right in the middle of the country, in the most rural of areas, we do have a drug problem, and we do have drug dealers that will kill to sell their illegal drugs to young people and others.

I would hope that we in the United States of America, we in Congress would never honor the goals of these drug dealers by legalizing drugs. Oh, it is true that spouse abuse and child abuse are on the increase, but that is no sign we should legalize them.

It is a problem that drug use is on the increase, and I share the thoughts of those here today that wonder what we can do to try to educate our people as to the serious nature of illegal drugs, as to how it can ruin their lives, as it has ruined so many in the past, and is continuing to ruin lives across our very country even today.

Mr. Chairman, I have taken enough time. I deeply appreciate the privilege of being here. I congratulate you on this timely subject and hope that our young people and adults across this nation will depend upon something else, perhaps in a spiritual way or some other way, rather than to lean on chemicals to survive the rest of their lifetime.

[Statement of Congressman Hubbard appears on p. 158.]

Chairman RANGEL. I want to thank you, Mr. Hubbard. Roy Dyson, the Congressman from Maryland?

TESTIMONY OF THE HONORABLE ROY DYSON, U.S. HOUSE OF REPRESENTATIVES

Congressman DYSON. Thank you very much, Mr. Chairman.

I think that this issue has generated a lot of interest in Maryland and, obviously, now in the nation as a whole, because you are having this hearing today.

I think the discussion of it is probably good for America. I don't know how good it would be if we actually go through the route of decriminalization. And I was very encouraged this morning to hear almost everyone—I can say that the panel was almost nearly unanimous in their position in the opposition to that.

Mr. Chairman, I think it would be a foolhardy and reckless proposal. I think it would have a serious impact on our society and, I think, most importantly, on the American family.

The issue has been raised, and so I feel obligated, along with my other colleagues from Maryland and elsewhere in the country, to express my strong opposition to the idea.

I represent a primarily rural district in the State of Maryland. And, quite frankly, Mr. Chairman, we always felt drugs and problems like that were your problems, problems of the urban areas of this country.

And, in fact, when I attended school in St. Mary's County, Maryland, it was even very difficult to get any kind of information on the issue. And, yet, we are having an increasing number of drug-related crimes and, in fact, between the years of 1986 and 1987, in one of the counties that I represent the number of drug offenses increased by 114 percent.

Like I said, we had always expected that those are the kinds of things that happen in the urban areas of America, not in rural America, where issues like family, church, Little League baseball, weekend picnics have been traditionally the most important things in our lives.

Now drugs have invaded this sanctuary and, unfortunately, are becoming a part of almost every community in rural Maryland and throughout rural America.

Mr. Chairman, you deserve a lot of credit and certainly the whole of the entire Select Committee for your efforts in passing the Omnibus Drug Bill and in getting this issue the attention that it deserves.

I think we should be exploring new ideas to win this war. I don't think that we should return to the old idea of decriminalization. I think it is a back-door attempt to legalize the purchase and the sale and the use of drugs.

And I, rather interestingly enough, listened to the Chairman of the Foreign Relations Committee on how that would come about. I think we all smiled, and I think we were all amused. But if it did happen, it would be a very frightening thing for America.

I don't think the decriminalization would alleviate the drug problem. I think it would increase our problem. Today, Mr. Chairman, I believe we are at a very crucial point in our efforts to win this war.

Again, as I said, you and the Committee deserve a lot of credit for that. I think it is a transition period that we are in between our previous failures, and I hope what will happen will be our future successes. Again, you deserve a lot of credit for that.

I really have no illusions that a renewed effort to win the war on drugs will be easy, and I don't think you do either. I realize it is going to take a considerable amount of time and money.

The authorization for the bill that just passed is $6.1 billion, and that is $6.1 billion we don't have. But I think it is worth it. I strongly believe that what this will mean is the savings of the lives of our nation's youth. And I think that that is an effort we must make.

Mr. Chairman, I thank you for the opportunity to be here today, your attention that you are giving to this, and I would also ask unanimous consent to submit my entire report for the record.

Chairman RANGEL. Without objection.

[Statement of Congressman Dyson appears on p. 162.]

Chairman RANGEL. And I thank the gentleman from Maryland.

Former Speaker of the Maryland State House of Delegates, Benjamin Cardin, we welcome your testimony.

TESTIMONY OF THE HONORABLE BENJAMIN L. CARDIN, U.S. HOUSE OF REPRESENTATIVES

Congressman CARDIN. Chairman, thank you for this opportunity to testify, and I want to thank you for your leadership in this Congress in the war against drugs. You have truly been our hero and our champion, and we very much appreciate these hearings and this opportunity to testify.

I would also like to extend a special welcome to the Mayor of Baltimore, who will be testifying later, Kurt Schmoke. He shocked the people of Baltimore and, indeed, the nation last April, when he made his suggestions that we should seriously consider the decriminalization of drugs.

And I think he has accomplished at least one of his objectives, and that is to focus national attention on the drug issue, that we are not doing what we need to do as a society to deal with the drug problems and that we need to look at new commitments and new solutions to this problem.

In preparation for today's hearing, I scheduled five community forums in my district, which includes parts of Baltimore City, Baltimore County, and Howard County. And the views expressed at those hearings, I think reaffirmed my own personal views in regards to the drug problems that we have in our community.

And, Mr. Chairman, I would like permission to submit my full testimony for the record, as it may be revised by one more hearing that I am having this evening in my district.

Chairman RANGEL. Without objection.

[Statement of Congressman Cardin appears on p. 166.]

Congressman CARDIN. Now, if I might just summarize very briefly, the overall sentiment in my district supports my own personal belief, and that is against the decriminalization of drugs. I think it is the wrong message.

As we look for solutions to deal with the drug problems, we have to deal with our youth and educate our youth and work to prevent more drug abuse in our community.

And I think it was stated best by Scotty McGregor, a former pitcher for the Baltimore Orioles. Scotty is in the hearing room today with Tippy Martinez, two former pitchers from the Baltimore Orioles. God knows we could have used them this year on the field in Baltimore.

Both of these individuals are role models and heroes in our community in Baltimore. Scotty now has a new role. He is a pastor in Baltimore, and he heads up Athletes Against Drugs. He goes into our classrooms and works with young people to tell them the dangers of drug abuse and to work with their problems.

And let me, if I might, just quote from his statement, "Our kids have been told what is illegal is wrong and what is legal is right. Now if we tell them it is legal, they will be confused and we will be sending a mixed message to them."

I agree with Scotty. I think it would be a mixed signal to our youth as we try to deal with this issue. As part of my statement, I have Scotty McGregor's statement, Joe Gibbs, Rosie Grier, Meadowlark Lemon, all opposed to decriminalization. These people deal with our youth and know what impresses our youth, and I think we should listen to their comments.

A key element is a greater emphasis on education, prevention, and treatment. We have a program in Baltimore called "First Step." First Step costs a little over $1,000 per person who participates. It deals with high school students who have a substance abuse problem.

The program has been very successful, Mr. Chairman. We have about a 75 percent success ratio in reaching out to these children. But do you know what the problem is? There is a three and a half month waiting list to get in that program today because of a lack of funds.

And do you know what happens to a person who seeks treatment and can't get treatment for three and a half months? That person is going to turn to crime. The problem is going to get much more severe. It is going to cost society a lot more money than that approximately $1,000 would cost if we had adequate treatment programs.

Chip Silverman, a special advisor to Governor William Donald Shaefer on drugs, summed it up best when he said, "We have given lip service to the war on drugs. There are currently 600,000 dysfunctional substance abusers in Maryland. Education is the only way to change society's attitudes towards drugs, and education takes money."

Over and over again, the people in my district remind me that as we deal with substance abuse, drugs are just one problem. Let us not forget alcohol and tobacco, that we must deal with all of the problems that we have in our community. Many drug abusers also have an alcoholism problem, and we need to deal with the entire issue.

As we look for a solution in Congress, let me just offer one caveat, if I might, and that, I think, was summed up best by Mark Antell of Howard County, when he says, "I am concerned about the danger in eroding our civil liberties in waging a national war on drugs."

A person last night told me at our forum which Congressman Mfume attended, "You know, it is a war against drugs, not a war against our Constitution." And I would hope that we would be reminded of that. I think too often a couple weeks ago or last week, when we voted, the Congress was not mindful of the fact that the war is against drugs, not our Constitution.

Mr. Chairman, there is no easy answer to this problem, as you know. We need to adopt a comprehensive approach to substance abuse that includes a foreign and domestic policy sensitive to the urgencies of interdiction efforts, stricter enforcement of existing laws prohibiting drug activities, more resources to educate our youth of the dangers of illicit drugs, and treatment programs without waiting lists to get people off the drugs.

I congratulate you for these hearings. I look forward to the results of these hearings and to working with this Committee as Congress deals with these issues.

Thank you very much.

Chairman RANGEL. Thank you, Mr. Cardin.

And now we will now hear from Kweisi Mfume, who was the first member of Congress to ask to testify in front of this Select Committee, and he is the last one to do so.

TESTIMONY OF THE HONORABLE KWEISI MFUME, MARYLAND, U.S. HOUSE OF REPRESENTATIVES

Congressman MFUME. But the last shall be first. Good morning, Mr. Chairman, and thank you very much. I want to express my sincere appreciation to the members of this Select Committee on Narcotics and especially you for your leadership in efforts in seeking a sound and rational approach to dealing with the problem our nation is experiencing with not only drug use, but drug abuse and drug trafficking.

In particular, I would like to thank the Committee for this opportunity to contribute my ideas to attempt to at least further debate on this issue, Mr. Chairman.

Let me preface my remarks by stating on the record, unequivocally, that I am strongly opposed to the concept of legalization or decriminalization. It is, however, extremely important, I think, for this debate to take place, even though we may discuss unfavorable solutions and undesirable effects, than to allow us to fall into a realm of misinformation, false hope, and disillusionment, especially when the nation looks to those of us here in Congress for some sense of leadership and guidance on this issue.

Mr. Chairman, there is no doubt that both proponents and opponents on both sides of the issue agree that drugs are tearing the nation apart by the seams. In fact, there is no more important issue threatening our society, obviously, than the flow of illicit drugs into our streets and, ultimately, into our communities.

It has been estimated that 23 million Americans use an illegal drug at least once a month and that 6 million of these use what is becoming known as the "drug of preference," cocaine.

Drug abuse affects victims from all racial, social, economic, and ethnic backgrounds, as has been testified here today already. And although chemical addiction is not a new problem for us, it now has the potential to do even greater damage, because drug use is so prevalent among teenagers and young adults.

High school students, college students, and other young adults in the United States use illicit drugs to a greater extent than young people in any other industrialized nation in the world.

So I can understand that, out of frustration and out of dismay about the pandemic use of drugs in this country, many will seek alternative solutions to failed policies. However, I am ardently opposed to the proposal of legalizing narcotics, no matter how well intentioned that proposal may, in fact, be.

Some argue that legalization or decriminalization of drugs, as we know them, will, in fact, take the profit out of the drug trade. Well, it may, in fact, do that.

Let me say to you and to remind myself that the drug trade is driven by profit, but drug use and drug abuse are driven by demand. And it is the reduction of that demand to which I believe greater national attention must be given.

Legalizing drugs, in my opinion, will have a detrimental effect on young people so much so that those who we are trying to protect will, in fact, be hurt by what we do.

Past experiences with alcohol proves that a drug that is legal for adults cannot be kept from reaching kids. And I believe that, under any proposal to legalize or to decriminalize, more and more of our nation's children would experiment with drugs.

Someone whom we all know, two months ago, said something that bears repeating: He said, "Facts are stubborn things." Well, they are. Studies have found that more exposure and curiosity leads to more usage, which in turn leads to more and greater addictions. And that is a fact.

It has been estimated that 75 percent of all regular drug users become addicted, and that is a fact. Already we have seen the devastating effects that drugs have had in communities where exposure probabilities are significantly higher.

An approach, again, in my opinion, aimed at decriminalization serves to exacerbate the problem rather than to alleviate it. Legalizing drugs is not the answer. It creates more questions than there are answers.

As the Chairman has previously asked, who will get the drugs; what drugs will, in fact, be dispensed; in what communities will they be made available; and what will happen to health insurance rates, just to name a few.

More disturbing, Mr. Chairman, is the fact that we just don't know what the effects of legalization in our society will, in fact, be. Proponents are forgetting the fact that the greatest impact in such an approach will fall upon America's greatest resource, our young people.

At present, we can only speculate what the outcome of legalization would be. There are some who point to the examples of England and Holland, Netherlands, where legalization has been experimented.

The results in England have led to stronger usage and a more vibrant black market, as well as an increase in the number of heroin users, a policy in England which eventually had to be eliminated by the British Government.

In Amsterdam, where marijuana is legal and other illicit drug use is tolerated to some extent, crime remains a problem and those individuals addicted to hard drugs continue to use them.

So drug legalization has not worked in other countries. There is increasing probability that it will not work in ours. Additionally, more and more babies in this country are born addicted to drugs.

And so the question then becomes: How can we dispense drugs under a concept of legalization, when it is already apparent that chemically dependent mothers continue to use drugs even during pregnancy?

And so we must not, I believe, allow an entire generation to be lost as a result of a proposal that we just don't know a great deal about. As a nation at risk, I think we must make a landmark commitment to effectuating the demand side of the drug equation.

Someone said at the Town Meeting that Congressman Cardin and I were at last night, something that also bears repeating. He said, "We really aren't in a war on drugs. If we were to spend just 25 percent of what we spent in the war on Vietnam, we would, in fact, be able to make an impact." But a war is just that; it is an all-out assault. And we still, in many respects, have yet to do that.

And so if this is, quote, unquote, a "war on drugs," we have to consider, I think, a change in strategies, but we must not give up in defeat through legalization.

And I believe that over the next few years, we will be able to turn the tide on drugs as we seek new and preventive treatment methods coupled with tough laws on drug use and drug trafficking.

And so, Mr. Chairman, I again thank you for your many years of leadership on this tough and painful issue. I look forward to hearing the testimony of our distinguished guests today.

I would ask unanimous consent of the Committee that I might submit into the record of this hearing several pages of written testimony from concerned citizens in both Baltimore City and Baltimore County, who could not be with us today, but who cared deeply about this issue, and certainly would like the benefit of sharing that commitment through their testimony with this Committee.

I will, with that, yield back the balance of my time as a member of this panel and await the direction of the Chair as to the introduction of the first guest on the next panel.

Thank you, Mr. Chairman.

[Statement of Congressman Mfume appears on p. 173.]

Chairman RANGEL. I thank the gentleman from Maryland for his contribution, the entire panel; not only for their testimony and contribution this morning, but for what they have done over the years in the United States Congress.

I invite those members that have the time to come and join with us here as we take testimony from witnesses who are not members of Congress.

I would like to point out that on our panel here, on the Select Committee, we have been joined by Clay Shaw, from Florida, now a member of the Ways and Means Committee, no longer a member of the Select Committee, but because of his interest and outstanding contribution over the years, we will always consider him a part of our ongoing operation.

And we thank you for taking time out to join with us today.

As the witnesses leave to join us, those that will, I would like to reiterate that we will be breaking around 12:30 or 1:00 o'clock, that we also, after the next panel, will be rotating. And we will be asking those spectators who are not witnesses to allow others to come in.

And I also would like to point out to the next panel of witnesses, as I will every panel, that we ask you to restrict your testimony to five minutes to give the members of the Select Committee an opportunity to better question you.

For the purpose of introducing our first witness, I will yield to the distinguished gentleman from Maryland, Mr. Mfume.

Congressman MFUME. Mr. Chairman, thank you again very much. I am honored to welcome our next witness, whom I consider to be one of Maryland's most distinguished citizens, my good friend and colleague, Mayor Kurt L. Schmoke of Baltimore, whom I have had the pleasure of knowing and working with for more than eight years.

Mayor Schmoke has demonstrated tremendous leadership and has worked tirelessly at the local level in anti-drug efforts. As a former United States Attorney for Baltimore and as Mayor, he has, in fact, been in the forefront of combatting drug abuse and crime. And I look forward, as do many more citizens in the City of Baltimore, to the continued leadership of Mayor Kurt L. Schmoke.

Several months ago, it was the Mayor, as we all know, who called for a national debate on the issue of decriminalization of illicit drugs, which has, in fact, moved to bring us to this meeting.

The Mayor has effected national attention towards the drug problem. And although he and I do not share the same opinion on the issue, I, like many of you, look forward to hearing his testimony today.

So thank you again, Mr. Chairman, and I present to this Committee the Honorable Kurt L. Schmoke, Mayor of the great City of Baltimore.

Chairman RANGEL. Mayor Schmoke, welcome. We also would like to welcome to the panel the distinguished Mayor of the District of Columbia, who certainly has gained a national reputation, not only with the Conference of Mayors in mobilizing resources to fight against drugs, but certainly in sharing with the Congress the problems that are being faced in the District and some of the solutions he has sought.

Also, from Charles Town, West Virginia, the panel welcomes the Honorable Donald Master, who is the Mayor; as well as the Mayor from Hartford, who participated in some of the discussions that we had over the legislative Congressional Black Caucus weekend, the Honorable Carrie Saxon Perry.

Before we start off with Mayor Schmoke, I would want the record to remain open for the testimony of Congressman Steny

Hoyer of Maryland. It was earlier indicated that he wanted to share his views publicly on this issue. I assume he had a legislative conflict. And so if there is no objection, the record will remain open at that point that we heard from members of Congress, for Congressman Hoyer.

[Statement of Congressman Hoyer appears on p. 540.]

As I indicated, because of the number of witnesses and because we want to make certain that the members of the Select Committee have an opportunity to inquire, and as staff has already suggested to you, we would ask you to limit your formal testimony to five minutes, with the full understanding that your entire statements will be entered into the record.

Mayor Schmoke, we welcome your appearance here before the Committee, and we are prepared to take your testimony.

TESTIMONY OF THE HONORABLE KURT L. SCHMOKE, MAYOR, BALTIMORE CITY, MD, ACCOMPANIED BY DR. MAXIE COLLIER

Mayor SCHMOKE. Thank you very much, Mr. Chairman. I would also like to indicate that with me, seated to my right, is Dr. Maxie Collier, who is the Commissioner of Health of Baltimore City.

Mr. Chairman, I would like to begin by thanking you and the members of this Committee for holding this hearing. I know full well that the mere discussion of drug decriminalization frightens many people, but the national attention this subject has received in the past few months indicates that our citizens are fundamentally dissatisfied with our current policy and are ready to at least listen to alternatives.

That is why I am very pleased that this hearing is being held, and I hope that this is only a first step in a national reexamination of our drug laws.

Seventy-four years after we took the problem of drug addiction out of the hands of physicians and put it in the hands of law enforcement, this is what America looks like: $10 billion a year is being expended to arrest and prosecute a small fraction of this nation's drug users.

Nine out of every 10 drug addicts are going untreated. Children growing up in our inner cities are being bombarded with the message that joining the drug trade is the road to easy riches. And school systems are having to ban the wearing of beepers by school children working in the lucrative drug trade.

Innocent people are being gunned down in street battles waged by drug traffickers warring to control profits obtained from the sale of illicit drugs. Public officials, including police officers, are being corrupted.

Tons of adulterated drugs of unknown purity are being sold openly on our streets to our citizens, young and old. American foreign policy toward our Latin American neighbors is confused because of drug traffickers.

And then there is A.I.D.S. This disease is spreading throughout cities primarily through intravenous drug users sharing needles and having sex with innocent partners. Current drug laws hurt, rather than help, the fight against A.I.D.S.

These are the results of this nation's 74-year war on drugs. I believe our country deserves better. I am convinced that through research and open-minded analysis, followed by honest and thorough debate, we can develop a reasoned strategy to help us achieve the more humane America which we desire.

I have set out an analytical argument for decriminalization in my written testimony, which you have, and I believe, Mr. Chairman, that it addresses many of the questions you have raised about decriminalization. But I will make a few brief comments.

The drug problem has two basic components. First is addiction. It has been demonstrated that the criminal law enforcement system's ability to do anything about the medical problem of addiction is very limited.

The second component of the drug problem is drug-related crime. And here the criminal law enforcement system has not only failed to solve the problem; it has worsened it.

By criminalizing the manufacture and sale of certain drugs, we have created an enormous black market in those drugs. Income from that black market has been estimated by the President's Commission on Organized Crime to be worth up to $110 billion annually.

The size of the black market is illustrated by the fact that several hundreds dollars' worth of coca leaves can be worth, as cocaine, hundreds of thousands of dollars on the streets of the United States.

With those kinds of profits, the drug traffickers will resort to any form of criminal activity, no matter how heinous, to keep their product coming to the American market. Those profits also allow traffickers to lose some drugs to interdiction without their business being hurt.

Our response to drug-related crime has been to try to prosecute our way out of it. But it is an effort that is destined to fail. The criminal justice system can handle, at best, only a small percentage of drug offenses.

750,000 people were arrested last year for violating drug laws. In Baltimore over 13,000 were arrested. Yet, as large as those numbers may be, they are only a small fraction of the total number of drug law violations.

Now, some argue that we are not being tough enough. But more arrests won't help. Our prisons and jails are already dangerously overcrowded, and many cities and states are under court order to reduce their prison populations.

On the federal level, one-third of all federal prisoners are incarcerated for drug law violations. More prisons can be built at enormous expense, but we could never build enough to incarcerate all drug offenders, even if we could catch them, which we can't.

Similarly, we cannot seal the borders to drugs. We are only now probably interdicting 10 to 15 percent of the illegal drugs entering this country, and much of that is probably based on tips received from competing drug traffickers.

Recently, there have been calls for the use of the military and other efforts to increase interdiction. At best, such measures would tighten the supply only enough to increase the price still more, which means more addicts breaking into more houses to steal more goods for more money, earning even higher profits for drug criminals.

Since I began speaking out about this subject in April, I have made an effort to try to get people to think about illegal drugs in the context of legal drugs, because that is the first step towards dealing with drugs in a way that will improve life for the vast majority of the people who live in our cities and don't use drugs.

Cigarettes will kill hundreds of thousands of people this year, as they did last year and they will next year. The Surgeon General recently called nicotine as addictive as cocaine and heroin, but we haven't made cigarettes illegal. Instead, we have left it to the public health system to address the problem.

And that system has had considerable success. Fewer people are smoking, and also organized crime is earning very little from tobacco and the U.S. Treasury is earning billions in cigarette taxes.

As for alcohol, we tried to make it illegal and learned a painful lesson. If Government doesn't regulate the manufacture and sale of alcohol, criminal syndicates will take over and bring a reign of terror down upon our cities, which is exactly the situation we have today with illegal drugs.

I propose that we begin a phased-in process of fighting drug addiction as a public health problem, not as a crime problem. I propose we take these initial first steps: one, eliminate criminal penalties for marijuana possession and reallocate resources from interdiction efforts to drug abuse prevention programs; two, permit public health professionals to distribute methadone, heroin, and cocaine to addicts as part of supervised maintenance or treatment programs; and, three, establish an independent commission to study substances of abuse, including tobacco and alcohol, and make recommendations on how they should be regulated based upon their potential for harm.

America must rethink its approach to the drug problem, and I believe that, at present, we are paying too high a cost for so little benefit to our citizens.

Thank you, Mr. Chairman.

Chairman RANGEL. Thank you, Mayor Schmoke.

[Statement of Mayor Schmoke appears on p. 180.]

Chairman RANGEL. We will now hear from Mayor Barry.

TESTIMONY OF THE HONORABLE MARION S. BARRY, JR., MAYOR, WASHINGTON, DC

Mayor BARRY. Mr. Chairman and members of the Committee, let me indicate my great pleasure to be able to join these visionary outstanding mayors before this Committee and to commend you, Mr. Chairman, for your leadership of the Committee, and members of the Committee, in this area of illicit drugs and all that which follows.

Mr. Chairman, I would like to just highlight my testimony and in some instances go beyond my written testimony in the sense that, notwithstanding the hard work of this Committee, the visionary leadership of the Chair, the action of the Congress, the inaction of the Executive Branch of Government, the hundreds of people who have been arrested, the millions and billions of dollars that are being spent on incarceration, the fact of the matter, Mr. Chairman and the Committee, is that there are more drugs in America today, on the streets of America, heroin, cocaine, marijuana in 1988 than there was in 1987.

Here in Washington, since August of 1986, the Metropolitan Police Department has arrested some 41,123 people. 23,801 of those were related to a drug-related activity, either possession, distribution, or crimes associated with it.

Yet, the fact remains that in Washington, as in most of our major cities, including Baltimore, there are more drugs on the streets of America in these cities than ever before.

Therefore, one would have to say: What has gone wrong? What is not working? And I think we have to look at it very critically without being critical of the persons who were involved.

We must look at drugs, I think, in five categories. We have sort of looked at it holistically as opposed to dissected. You have the people who are addicted physically and psychologically. They are the ones who really don't commit crimes. They don't rob people. They just have a psychological and physiological need.

I believe that we ought to treat this category of people as medical problems. They should not be incarcerated, should not be arrested, but should be treated medically.

There was a story in this morning's "Post." I don't usually believe all I read, but this had some elements of truth in it. "My family has been going through the whole addictive process for about six years. My 13-year-old son has been riding the buses up and down 95 from Atlantic City to New York City and to Boston, Syracuse." Clearly, this family does not need to be jailed; they need medical treatment.

You find others who start out physiologically and psychologically addicted, but find they have to commit crimes in order to support their habits. They too ought to be treated as medical problems. They don't want to commit crimes. They don't want to rob people. But they have to to satisfy that craving for cocaine or for heroin or, in some instances, marijuana.

The third category is those persons who are mid-level street dealers. They are the ones who are not necessarily addicted. They are the ones who are really in this for business, who have several people who are runners and couriers and holders of drugs.

In my view, that is where law enforcement ought to kick in. These ought to be the people looked to in terms of law enforcement purposes to try to arrest and incarcerate those kind of people.

Another category is the international drug thugs. These are the people who are in these six or seven South and Central American countries that grow the crops, buy the crops, process the crops, get it to this country. Those are the persons who in this country make millions of dollars off of it, yet not use it.

They are the ones that have been left out of this equation. We know that in Panama and Peru, Colombia, Bolivia, Paraguay, Mexico, 80 to 90 percent of the cocaine is grown there, processed there, and sent here.

This country has not moved quickly enough and strongly enough against these international drug thugs. The governments of these countries sometimes are less armed, less financed than drug war lords. They have more arms, more money, and in some instances, control the governments more strongly than the governments themselves.

In those instances, it seems to me, Mr. Chairman and members of the Committee, we have to take drastic actions. We invaded Grenada, which I don't think we should have. We mined the harbors of Nicaragua, which I don't think we should have. They weren't necessarily a threat to this country. But drugs from those six or seven countries are a direct threat to the fabric of America.

I believe that if the governments of these countries cannot control this trafficking, the United States government ought to go in, destroy these crops, blow up these chemical labs, eradicate the source of cocaine. The heather snake is there, not in our cities.

Mayor Schmoke, Mayor Master, Mayor Perry, and I are the tail end of this. You don't kill a snake by cutting off his tail; you kill a snake by cutting off his head.

The fourth category of people, sort of related to the third, are the bankers, real estate agents, the car dealers, the jewelers. What about all of those who help to launder this 140, 150 billion dollars of illegal money.

Ball players and young people can't consume this much dope. Bankers, real estate agents, car dealers, jewelers, furriers, yacht salesmen, boat salespeople, fancy car people, they are the ones that are participating in this laundering of money.

The Congress has acted recently to impose stiff penalties on consumers of drugs. What about the consumers of money? What about those real estate people who take cash for 80, 90 thousand dollars' worth at a time?

And the fifth category, which is one we really ought to focus on even more, is our young people who are 13 and 14 and 15, 16 who don't necessarily use drugs, but are selling it to make fast money, who won't work for $3.35 an hour because they can make that much in about 10 minutes. They are the ones who are being caught up in being couriers and being runners and being holders of drugs.

I think we need a multifaceted approach: medical treatment for those who are addicted and those who get addicted and have to steal for their money; and action for the street level, mid-level person, international drug thug, and our young people who are getting caught up in this.

And so I say it is time to rethink our policies. No offense to anybody in this room, but our policies have failed. Mayor Schmoke, I don't think would ever have launched a war on drugs.

If we got the defense budget, $291 million, take all the human services budget together, take all of housing together, all of transportation together, less than $261 million.

If we really were launching a war on drugs, we would be spending millions of dollars mobilizing the country as never before in order to try to really have a war. We have had a little scrimmage, I think. We have not won that very well.

So what we mayors are pleading for is a new policy, a new direction, a new attitude. Just saying "No" is not enough. Just saying to young people, "I believe as I do," in a drug-free society, a drug-free work place, a drug-free individual, a drug-free city, that is not enough. To say it is one thing; to have it done is another.

Our young people are dying every day. We have had over 245 murders here in Washington. Seventy percent of them are drug-related. Over 800 shootings by young people, people who kill each other over boom boxes, over $10 vials of crack. Our young people deserve better. Our nation deserves better. And I think we can have better if we take a different approach to it.

I want to thank the Committee. And I sort of got a little carried away on this, but this is so emotional with me and I feel so strongly about it that we have to just give up all our notions about what has been our notions of the past, develop new attitudes, be flexible, listen to new directions.

Because what we are doing now, regardless of how hard we have worked, how much we are struggling, how visionary this Committee has been, Mr. Chairman, how hard you have worked, what has happened is we have failed, because results show there are more drugs on the streets of America than ever before.

Thank you.

[Statement of Mayor Barry appears on p. 212.]

Chairman RANGEL. Mr. Mayor, I am moved by your eloquent testimony. Can you share with us what your views are on the question of legalization or decriminalization of narcotic drugs?

Mayor BARRY. Well, I think the issue ought to be discussed. I don't know enough about the impact of cocaine addiction. When you talk to physicians and others, you find that cocaine addiction is different than heroin addiction. Heroin, as I understand it, the craving can be blocked with methadone. Another dose of heroin can stop a craving of it. Whereas, the cocaine, the more you use, the more you want.

And I am not necessarily in favor of legalization or decriminalization, but, on the other hand, I think a democracy can stand a healthy debate on the subject. This democracy is strong enough for us to have disagreements and different points of view, but what is missing, Mr. Chairman, is research.

None of us really know the long-range impact of these drugs. None of us know how to treat cocaine addiction, for real. I will give you an example. I know a family who recently spent $15,000 to try to get their son cured of crack addiction. He stayed off of crack for about four weeks. I've known him since he was 14. He is now 24.

I saw him about three weeks after he had come out of the psychiatric place where he was. He said, "Mr. Mayor, I want to stop this, but I can't. Every time I think about the last high, I want to do it again. I want to work, but I can't."

And so I asked him, you know, does he want to be treated. He said, "I want to, but they don't know how to do it. They put me in this place. I thought I had kicked it, but I'm back out."

That is typical of what happens in this country. We need research. We need to talk about the situation.

So I'm not prepared to say whether I am in favor of decriminalization or legalization, but I am in favor of good debate, research, analysis, and facing the grim reality that our situation is getting worse.

Chairman RANGEL. I want to move on, and certainly no one can argue with you on research. But it is a little bit difficult, Mr. Mayor, to talk about debate when nobody is supporting legalization or decriminalization. There's no one to debate with. But I certainly support the need for more research.

Mayor **Barry**. I think the Committee will probably hear from some people who are probably much further along this road——

Chairman **Rangel**. Right.

Mayor **Barry** [continuing]. In terms of legalization or decriminalization.

Chairman **Rangel**. Okay. Then we will see.

We now have the Honorable Doctor Master, the Mayor of Charles Town, West Virginia.

TESTIMONY OF THE HONORABLE DONALD "DOC" MASTER, MAYOR, CHARLES TOWN, WV

Mayor **Master**. Thank you, Mr. Chairman. I sincerely appreciate your efforts to have this Town Meeting. This is the true meaning of democracy, and we appreciate it on this side of the panel.

My name is Donald Cameron Master, a practicing veterinarian and currently serving my 21st year as Mayor of the City of Charles Town, West Virginia, a small community of 2,893 people, located 60 miles west of Washington, DC. It is a beautiful historic town surveyed by George Washington and named after his brother Charles, and where 200 years of history blends well with our more recent achievements.

What, then, does this town have to do with the drug problem? If it is happening in little old Charles Town, it is happening throughout the country. Every small town in America has its real or potential cocaine alley.

Two years ago, the slow and steady invasion took over the town with blatant drug pushers tapping on windshields of cars as they slowed down for stop signs, asking, "What can I sell you?" Not one pusher to a car, but several.

In the beginning, our entire police force numbered seven. We were unable to cope with the invasion. Gun battles between pushers occurred on three occasions. I was fearful of innocent citizens being caught in the cross-fire.

In desperation, in January of this year, I contacted Governor Arch Moore for help. On April the 9th of this year, 77 law enforcement agents, state police, F.B.I., D.E.A., A.T.F. came to town, and at 3:45 p.m. on a Saturday afternoon, the raid began.

By 6:00 o'clock, the figures were tallied. Five policemen were hospitalized; one was shot; a cruiser totaled; and 44 suspects rounded up with federal indictments. Only five spent one night in jail.

Drugs were again being sold on the streets Sunday afternoon. The raid cost half a million dollars. If you live in a big city, you may think a drug raid that has 44 suspects isn't important.

Let me put that figure in a proper perspective. On a population ratio basis, if the raid had occurred in our nation's capital, there would have been 12,000 people arrested. And I believe that even the Mayor of Washington, D.C. would agree that that would be a big, big raid. We have lost the war on drugs. Money, vast amounts are fueling the problem, and the criminal element is in command.

On one previous arrest of a pusher, he was released within 24 hours by a defense lawyer from Florida. On another occasion, a seller with cocaine, pot, and crack in his possession could have been charged $20,000 for each drug, a total of $60,000 bond. The local magistrate released him for $400 bond, $40 was paid by a bondsman. And he was back on the street before we could get back to the police station.

We have found that federal indictments with much stiffer penalties are the way to go rather than local or state actions. What should be included in a national anti-drug program? Certainly we should continue to expand our cooperation with the United Nations, regional organizations, the major producing nations, to achieve a slow down in the quantity of illicit drugs entering the world trade.

Simultaneously, we should strengthen our own domestic efforts to prevent such drugs from entering the United States. We should promote a massive educational program, beginning at the elementary level, to convince our citizens of the dangers of drug usage and the value of better lifestyle.

We should continue to support the efforts of our police, and our courts should hand out tougher sentences and larger fines for those found guilty of drug trafficking.

We must improve our methods of treating and rehabilitating drug misusers, because the drug problem is as much a health problem as it is a crime problem.

Now what about legalization? No one knows for certain if legalization would work in this country. I would agree that 90 percent of the people in Charles Town would oppose legalization.

We are surrounded by a ring of fear, the fear that the number of addicts would increase substantially, followed by a second fear that the United States would be taking a giant step toward becoming a permissive society if we legalize drugs.

People remember the questionable results of the wars in Korea and Vietnam. They have witnessed the emergence of the largest national debt in the history of our world. They don't like the decline in parental guidance and family traditions. And they are acutely aware of the humiliations that we have experienced in our foreign relations with Iran, Panama.

To many, the legalization of drugs would be another cop-out, because we haven't been able to find a better solution. Legalization of drugs is one solution? It deserves consideration. It may become the last alternative in our battle to save our society and our country from the ravages of a national drug problem.

Mr. Chairman, I do have some suggestions, but no blanket solutions. 1. Marijuana. Under strict controls, I believe we can legalize marijuana.

Tobacco is the most addictive drug and, likewise, should also be controlled, first of all, by prohibiting cigarette vending machines. Small children tall enough to put money in those dispensing machines can begin a life of addiction. Dr. C. Everett Koop and educational programs have greatly reduced smoking by 23 percent in 20 years. Subsidizing tobacco production must be stopped by Congress. Tobacco farmers must be encouraged to grow other crops.

Marijuana should be sold only to those over 21 years of age and heavily taxed. We have been led to believe over the years that the use of marijuana leads to use of more potent drugs and to legalize it would increase the use. Not so.

In both Oregon and the Netherlands—I wish to object to what was heard earlier—it has proven not to be the case. After 12 years since legalization of marijuana in the Netherlands, consumption of marijuana has gone down markedly and has not led to the use of other drugs.

One reason it should be legalized, at least, is for medical purposes, to relieve pain and suffering for cancer and patients.

2. P.C.P., L.S.D., and the other manufactured mind-boggling drugs. Absolutely no discussion on the legalization of these drugs, only much stiffer penalties over all be enforced.

3. Cocaine and heroin. We must treat the use of these drugs as a medical problem, not a criminal one. We must, by all means, institute an educational program among our younger school children of the horrible consequences of drug use.

We must eliminate the demand, thereby eliminating the sale of drugs and subsequently eliminating the criminal element. In the face of knowing what horrible devastation the use of them can cause, to do drugs is utter stupidity.

For those without fear of its use and the addicts, we can't help them anyway, unless they seek it. If they are bent on "frying" their brains, so be it. We must change the attitude among users that it is the "in" thing to do; and for the rest of us fearful nonusers to show utter contempt and disrespect.

It is my belief that we could institute a program for users and addicts of cocaine or heroin as follows, purely a suggestion, merely a personal thought. Number one, designate one hospital within a given area for dispensing drugs to users and addicts. Hospitals are 24-hour-a-day, 7-day-a-week facilities.

Two, each addict would be registered with a confidential identification number only, thereby concealing his or her identity to the public.

Three, his identification number would be entered into the computer bank, and each time the addict needed a fix, the computer would record the date, time of the day, the number of times, and the dosage of drug used.

Four, during these visits, the addicts would be offered, on a confidential basis, the opportunity to join a drug rehabilitation program and tolerate his dosage eventually down to .0.

Five, each time the addict needed a fix, he would come to the hospital and get one at no cost or at hospital cost and with no criminal penalty. Twenty-five grams of pure cocaine costs the hospital less than $200—but worth over $10,000 on the street when cut by the addition of lactose powder.

This would amount to legalization of drugs but under a controlled environment. The present addict population would no longer need to buy or steal, thereby eliminating the profit margin for the pusher.

If this program were in force and someone were arrested for pushing drugs, the full weight of the law (Federal) should be brought to bear, because the selling of drugs would still be illegal.

Chairman RANGEL. Mr. Mayor, I resisted interrupting, but you are exceeding the five-minute rule. I hope that you may be able to summarize at this point because——

Mayor MASTER. Fine.

Chairman RANGEL [continuing]. We have any number of witnesses.

Mayor MASTER. Right. I will hand this in, but in closing, speaking more specifically, I fully support the instigation of the death penalty, required testing of those engaged in public transportation and public safety, the adoption of good-faith drug searches without warrants, and extended use of the Coast Guard and the National Guard in fighting drug intrusions, and stopping of all foreign aid to those drug-producing nations which do not cooperate fully in our efforts to eradicate the drug problem, and I support the idea of a $10,000 civil fine for drug possession.

I would suggest that marijuana be legalized for medical purposes for a two-year period with strict controls over the method of dispensing. If this works, then we may wish to consider full legalization with sales banned to juveniles.

And I thank you, Mr. Chairman.

[Statement of Mayor Master appears on p. 226.]

Chairman RANGEL. Thank you, Mr. Mayor. And I apologize for having to interrupt.

Mayor MASTER. That is perfectly all right.

Chairman RANGEL. I would advise witnesses that are here that——

Mayor MASTER. We know politicians.

Chairman RANGEL [continuing]. We have got to really restrict it to five minutes, and it would be helpful, since most all of us agree with the wonderful recommendations that are being made by the witnesses, if we could really get your views as it relates to legalization and decriminalization.

So if you could focus on that part, we will assume that all of us want better health care and education and all of those things, too.

Mayor Perry from Hartford, Connecticut?

TESTIMONY OF THE HONORABLE CARRIE SAXON PERRY, MAYOR, HARTFORD, CT

Mayor PERRY. Yes, Mr. Chairman. I want to applaud you because you are a magnificent long-distance runner in this whole concern about drugs, but I don't know if you are being totally fair narrowing me down. I guess it is the disadvantage in being the last one, but I do plan to be extraordinarily brief.

And I also want to applaud Mayor Schmoke for encouraging and urging this kind of debate.

I won't repeat what I did in my testimony when I appeared before the Congressional Black Caucus about the City of Hartford in the same kinds of hostile- holding that we have in our city because of the drug problem and that 80 percent of the crimes that are committed in our city are caused by drug addiction. But what I will do——

Chairman RANGEL. If the gentle lady will pause, I think at this point that we should break for ten minutes and respond to a vote.

The Agriculture Appropriations Conference Report is on. And we will come right back.

[Recess.]

Chairman RANGEL. The Committee will resume its hearing.

It is my understanding that Mayor Perry had to leave, and I hope that she will be able to return. Mayor Master is still with us. And Mayor Barry had to leave.

Mayor Schmoke, I think that you are really the only one who has made it abundantly clear that you want to go beyond discussion and debate——

Mayor SCHMOKE. Yes, sir.

Chairman RANGEL [continuing]. And try something and see whether it works.

Mayor SCHMOKE. Yes, sir.

Chairman RANGEL. And recently you held a conference in Baltimore in preparation for these hearings.

Mayor SCHMOKE. Yes, sir, with a wide divergence of opinions on the issue.

Chairman RANGEL. Well, that was my question. In going over your list of people, I wondered whether they were there to support your position or whether there was a wide difference of opinion as to the approach.

On your drug policy as a public health issue, you had six panelists. Did any of them disagree with your position?

Mayor SCHMOKE. Yes, sir. I know Dr. Klieber, who was one of the country's leading authorities, attended that forum. We also had the Chief of Police from Baltimore County.

Chairman RANGEL. Now, he wasn't on that panel, but on that panel——

Mayor SCHMOKE. There were several different panels. Oh, I'm sorry. There were several different panels.

Chairman RANGEL. On that panel, Dr. Trebach, Dr. Klieber, Dr. Cabel, Dr. Jonas, Dr. Snyder, and the moderator, Dr. Collier.

Mayor SCHMOKE. Yes.

Chairman RANGEL. It is my understanding that only Dr. Klieber differed with your approach.

Mayor SCHMOKE. And Dr. Snyder also talked about the need to treat this as a medical problem rather than a criminal justice problem. His testimony was simply the shift in the focus; if we are going to invest in resources in this problem, let the investment be weighted towards the public health side rather than the criminal justice side.

Chairman RANGEL. But I just wanted——

Mayor SCHMOKE. I understand. If the suggestion is whether we self-selected. That is not the case. I think it was simply a matter of the fact that I had made my position on the issue known, and many of the people who responded to the forum were people who had some interest in promoting that position.

Chairman RANGEL. Okay. That is what I wanted to clear up.

Mayor SCHMOKE. Yes, sir.

Chairman RANGEL. I want to thank you for your candor because, on the other hand, I have requested from you a list of people that supported your position, and you did submit that to the Select Committee. And we did invite all of your people, and I think the overwhelming majority of them agreed to testify. I wanted to make certain that the discussion, at least the testimony, would be well-balanced.

Are you satisfied that the United States is involved in a war against drugs and that we have, indeed, done all that we could under the existing system? You know, you have heard me many, many times indicate that we don't even have one rehabilitation program, not a single federal rehab program.

So, therefore, it would seem to me the frustration would be: What are you doing about that? We don't have an educational policy, and it would seem to me that a lot of people would be concerned about that.

We can't record where the Secretary of State has publicly indicated how he would want to get on our foreign policy agenda the eradication of drugs overseas. And as senseless as it may appear to try to protect our borders, certainly we have not received or heard from the Pentagon as to them being supportive.

The thrust of these many questions, even without getting involved with the questions of poverty and joblessness and homelessness, would mean that, should not we make certain that we exhaust all of our efforts in these areas in a so-called "assault" against drug addiction before we entertain the question of legalization?

Mayor SCHMOKE. Well, Mr. Chairman, I think that one of the things that we have to do, and the reason why I support this independent commission approach, is to do some research to determine precisely that question.

I think that we have. We have continuously escalated our law enforcement efforts against the drug problem since 1914. And from time-to-time, we have asked for new coordination, such as for the F.B.I. to get involved along with the D.E.A. We give more money from the old law enforcement administration in Justice Department to local police. And so we have escalated those efforts.

The question is: What has been the payoff? What benefit have we gotten from that? And then I think we have to look and say: Will doing more of the same lead to any different results than we have now?

And I have simply come to the conclusion that it will not. And the reason why I guess I continue to use the term "decriminalization" rather than "legalization" is that I am not saying that all drugs for all people should be freely available, as I indicated in my testimony.

I am talking about a phased-in process in which the medical community would begin to be able to deal with addicts; for example, by distributing cocaine or heroin as a part of a maintenance program. Methadone right now, for example, individual physicians cannot do that. They cannot distribute that.

So we have these incredible waiting lists for addicts. And I am calling for a flexibility in there. But in order to do that, we would have to decriminalize. We would have to provide an immunity for those physicians and for those patients to take the drugs legally.

Chairman RANGEL. Well, my time has expired. Do you have methadone clinics?

Mayor **Schmoke**. Yes, sir. A small number, with the same restrictions that——

Chairman **Rangel**. Are you satisfied——

Mayor **Schmoke**. No.

Chairman **Rangel** [continuing]. That they are successful?

Mayor **Schmoke**. I am not satisfied with the current approach. You have to be an addict, declare yourself an addict for a year before you can become eligible to get on the waiting list. Other physicians could treat those addicts, but they cannot now.

And one other issue. I think that the issue of A.I.D.S. does really crystallize for us why our approach is too inflexible and why there is a need for some change.

If I could convince the Committee that one of the best ways of fighting the spread of A.I.D.S., particularly in the urban environment, is by a clean-needle program, a needle-exchange program, so that people are not out there sharing dirty needles and transmitting A.I.D.S., if I can convince you of that, I would then have to say we would have to decriminalize the possession of hypodermics.

Because right now, in order to do a program like that, a person would have to admit two crimes: that he is a drug user and that he is in possession of a hypodermic.

Chairman **Rangel**. But if you were to convince me of that, would you not move further and try to convince me that by legalizing drugs, that the addict would be able to get a higher degree of purity and that it would be a cleaner process that he or she would be involved in?

Mayor **Schmoke**. Well, what I am saying is that right now the criminals control the quality, the quantity, the price of drugs, and I would prefer that the health system or Government control that, because there are some people, and I think we have to admit that, who have an addiction and who are going to be addicted for the rest of their lives.

I don't want them breaking into our houses anymore. I don't want them to continue to lure our children into this profitable drug trade. And I just think that we could destroy the market by allowing people access through the public health system.

Chairman **Rangel**. Think as to whether or not the legalization of liquor and cigarettes have restricted the number of users.

Mayor **Schmoke**. Well, Mr. Chairman, the problem there—and we can learn a lesson—is that after alcohol prohibition, we didn't continue to have "Say No" programs, or anything like that.

We went from saying it was illegal to actually promoting it as a social good, not only that it was socially necessary, but desirable to drink.

Chairman **Rangel**. Is there any question in your mind that decriminalization and legalization would not lead to an increase in addiction, any question in your mind?

Mayor **Schmoke**. Mr. Chairman, there are enough questions on this issue that I think it does deserve the further study of a national commission, and that is why——

Chairman **Rangel**. We will study. But I am asking, have you heard anybody that supports your position indicate anything other than it would increase the amount of addiction?

Mayor SCHMOKE. I have heard and seen studies, particularly as it relates to marijuana, that marijuana would——

Chairman RANGEL. I am not talking about marijuana; I am talking about——

Mayor SCHMOKE. Well, sir, there are——

Chairman RANGEL [continuing]. Cocaine, heroin, and crack, and P.C.P.

Mayor SCHMOKE. The problem is if. The Administrative Judge from the Drug Enforcement Administration just recently came out with a view that marijuana was "the most therapeutically safe substance known to man." That is a quote.

Chairman RANGEL. Okay.

Mayor SCHMOKE. Now why we have the restrictions that we do on marijuana and not on alcohol is a judgment that has to be made here.

Chairman RANGEL. Maybe I should have really refined my question and asked: Have any of the people that supported your position, your study, your debate, your discussion ever indicated that there is any question at all as to whether decriminalization of heroin, P.C.P., cocaine, its derivative crack would not cause an increase in the number of people that would become addicted?

Mayor SCHMOKE. I will answer that, but, as you know, Mr. Chairman, I have not called for legalizing crack or P.C.P. I just want to make that very clear.

Chairman RANGEL. Cocaine?

Mayor SCHMOKE. For addicts, allowing addicts to come to the health professionals for that substance, yes, sir. There have been a number of people that have raised the question because it is an experiment. We only have a theory.

We can't guarantee you exactly what will happen if we change to a decriminalized mode, but what we can guarantee is if we continue doing what we are doing, we will continue to fail and fail our children and fail the whole country.

Chairman RANGEL. Well, I don't want to exercise the prerogative of the Chair. I really hope to get a chance. I have Mayor Koch on another panel. But I will now recognize any member seeking recognition. Mr. Stark?

Congressman STARK. Mr. Chairman, I want to thank the panel, particularly Mayor Master, for taking what I suspect is a position that I agree with and is probably quite unpopular in front of this panel.

But I think he touches on an area, the decriminalization of marijuana, which, for all practical purposes, has happened on the West Coast of this country and with virtually no discernible increase of any abuse or traffic in that particular product and, to the relief, I might add, of many of our overburdened law enforcement agents who found it a pain, quite frankly, to be chasing around after a bunch of teenagers doing what they were going to do anyway.

Mayor Schmoke, I think, is a clarion call in a sea of fear and concern. I think it is a concern by people who are frightened, primarily about things of which they know little and who would like simply the answers. I think your high-risk position of decriminalization is to be lauded.

There have been suggestions by reputable researchers that held that addiction in this country is unrelated to the efforts to reduce demand or the budgets of law enforcement agencies.

There are a certain number of people who are disaffected or destabilized or uninterested in this society for a variety of reasons and a certain number of those who experiment with heroin will be addicted regardless of what we do. That may be correct, or it may not.

But if it were up to this Committee, we would never find out, because we would be afraid to try it. Why, I don't know.

But I want to suggest, as has been suggested here, would anybody advocate decriminalization? I would. I would join with you. I think that if we are so afraid, you will never achieve greatly in this world unless you risk greatly.

And it seems to me that I would just like to echo the statements of Mayor Barry. It isn't for lack of honest attempts. It isn't for lack of funneling funds to outstanding law enforcement agencies and great prosecutors. It hasn't worked.

It doesn't mean we should stop that, but I suggest that what I am hearing from this distinguished panel of witnesses is if we really want to be in the forefront of solving this problem, we might be willing to try other things.

There may be one or two who would suggest legislation, but I don't think that has ever been seriously suggested.

The idea that if we could take more than one out of ten of the addicts into detoxification and treatment centers in my district, many of those wouldn't come for fear of being branded a criminal. They might have a job. They would sure as hell lose it if they had to admit they were addicted and their employer didn't know it.

And I suspect, Mayor—and that is my question—is that wouldn't we really help many of the addicts who seek help. If we also take the stigma away or the fear away that the person who is attempting to get back in the mainstream would be precluded from entry to a job, to his community because of this brand, this scarlet "A" that goes on your head if you say "I am an addict"?

And I sense, in your concern about decriminalization, that that is the approach you are taking and not just saying, "Katie, unbar the door. Let's toss drugs like candy mints on every playground in this"——

Mayor SCHMOKE. That is correct.

Congressman STARK. I think anybody who characterizes your stand like that is somewhat guilty of baiting you on that issue.

Mayor SCHMOKE. Well, that is the one problem that I face in dealing with the term "legalization." We are such a law-oriented society with great respect for the law that whenever we hear the term "legalization," we assume that the person is promoting something as a positive good.

And that is not what I am talking about at all. I am talking about focusing on our addicted population, to change our approach to them, to reorient resources to fight the drug abuse problem through drug abuse prevention and education programs to try to cut down on the number of people who will become addicts in the future.

But most important is to deal with the crime that has changed the character of our cities. And nothing that we have talked about in terms of increasing the war on drugs is going to help us reduce that crime. It is going to get worse, because every time we put on the pressure-cooker, we just inflate the prices, which means more people have to steal more, that the gangs make more, that there are more shootings and killings, and nothing has been solved. And that is really the problem with our approach.

Let's get a flexibility in there that I think will be appropriate. It is just changing the strategy. I want to continue fighting against drugs. It's just, as I have said before, that if we are going to have a new war on drugs, let it be led by the Surgeon General, not the Attorney General. And I think that we will achieve more.

Congressman STARK. I want to thank you, and thank the entire panel very much.

Chairman RANGEL. Congressman Gilman?

Congressman GILMAN. Thank you, Mr. Chairman.

Mayor Schmoke, with regard to your thrust for decriminalizing, are you including heroin as part of the decriminalization process?

Mayor SCHMOKE. Cocaine and heroin, my suggestion is that we should allow health professionals to distribute cocaine and heroin to addicts as a part of a maintenance or supervised treatment program so that addicts don't have to go into the underground, to the criminal element to get this drug, that they can come to the public health system. Yes, sir.

Congressman GILMAN. Well, are you——

Mayor SCHMOKE. That is the distribution. I am not asking that we promote the sale or set it up in pharmacies. I am talking about a flexibility that allows the health professionals to distribute it.

Congressman GILMAN. Well, how would we distribute it, then, if you say it wouldn't be done through any sale? How would it be distributed?

Mayor SCHMOKE. It would be done through prescription. I am not talking about having, you know, in the stores, where you could walk in and anybody off the street could point up there and say, "Give me," you know, "a bottle of" whatever, "of cocaine" or "heroin." That is not what I am talking about.

I am talking about treating the addicted population as patients and then putting in massive resources into our public education and public drug abuse treatment programs to try to prevent nonusers from getting the substance.

Congressman GILMAN. Are you concerned at all about the proliferation of more abusers as a result of all of this?

Mayor SCHMOKE. Yes, sir.

Congressman GILMAN. When we decriminalized alcohol, we suddenly had a major increase in the number of alcohol abusers.

Mayor SCHMOKE. Yes, sir. I am very concerned. I am very concerned about the proliferation of drug users, and I think that it is going to continue under our existing approach to this problem. And I think that we would have a better chance at reducing the number of users if we go to a decriminalized mode.

Congressman GILMAN. Well, haven't we had a good demonstration of the effect of that when we decriminalized alcohol and found that we had increased the usage of alcohol in the country?

Mayor **Schmoke**. As I said, sir, I think there were clearly some mistakes made there that we can learn from. I mean, right now we have gone from a period in our country where we had massive law enforcement resources trying to create an alcohol-free America to a point where we have people using little dogs to sell beer on television.

I mean, we have completely—we have gone from one end to the other, and that is not what I would propose. I would not allow advertising of these substances. I am not trying to promote drug use.

As I say, I am a father. I have been a prosecutor. I have been a soldier in this war on drugs, but I think I know what works and what is likely to work. And I would just like us to rethink our approach, to look at the possibility of changing our approach to Schedule I drugs to allow physicians to administer those drugs through the public health system.

Congressman **Gilman**. What about the examples in Great Britain and in the Netherlands where they do have a maintenance program and where there has been tolerance in the Netherlands?

Mayor **Schmoke**. That is right. And the Netherlands, sir, I would suggest that it is safer today in Amsterdam than it is on many of the streets in the big cities in this country and that, in fact, they do not have the kind of violent crime problem that we have. There has been an increase in some property crime. I know the statistics.

But, again, what you have is a situation of an isolated country stuck in the middle of a continent where there is a different form of law of being asked to bear the burden of this change.

And I think if you look at the example of England, it is not a failure if you look at the drug problem as a twin problem of addiction and crime.

Congressman **Gilman**. Well, Mayor Schmoke, we have had police officials come to our community from Great Britain, we have been to the Netherlands and found that there was an increase in crime as a result of the tolerance and that the Mayor of Amsterdam, for example, was beginning to suggest greater controls and more stringent attention to the narcotics abuse and narcotics trafficking problem in his own community.

It would seem to me that if we take a good hard look and an objective look at these examples of a drug maintenance program and a drug tolerance program, we don't find a very enviable result.

Mayor **Schmoke**. We certainly don't find a very enviable result in what we are doing now. And doing more of the same isn't going to make those results any better.

And all that I am suggesting is that if we do want to take a good look at this process, that we do it by way of independent commission, examine what is working now, what we have done in the past, what have been the results.

I do think that after doing that, we will make substantial changes and rethink our approach. I mean, after all, the goal, I don't think is to decide today whether we should legalize or not legalize. I think the goal is whether we should rethink our national policies. And I believe that we should.

Congressman **Gilman**. Well, am I correct that your approach, though, would be to legalize and decriminalize?

Mayor **Schmoke**. My approach would be to decriminalize certain substances at this time and then have a commission look at each substance of abuse, including tobacco and alcohol, and determine, based on their potential for harm, how the country should regulate those substances?

Congressman **Gilman**. Just one more question with a decriminalization, though, you would include all of the hard substances of cocaine and heroin, P.C.P., and the other——

Mayor **Schmoke**. No, sir. That is what I tried to say. I am not including P.C.P. or crack. I am saying that at this point, I am talking about a phased-in process, and it is the process that I think is most important.

You are asking me to, you know, include some substances in that I think that there needs to be further study about their impact. I mean——

Congressman **Gilman**. Mayor, I'm not asking you to include it. I just wanted to know what your position was.

Mayor **Schmoke**. My position is, sir, that I would like to see health professionals have the independence to be able, if they felt that it was proper, to treat addicts in this fashion, that they be allowed to administer methadone, heroin, cocaine.

Congressman **Gilman**. And why do you draw a distinction on crack?

Mayor **Schmoke**. Why do I draw a distinction on crack? Because I do think that that is a substance in which this commission that I propose ought to study to determine its potential harm and compare that to all the other substances of abuse that we now have and determine how we regulate it.

I am trying to explain, Congressman. We have a substance out there that we know kills more than 300,000 people a year, and we make it legal. It is legal to sell nicotine to anybody in this country, and we promote it, and we subsidize it.

Now, by any standard that you apply to control dangerous substances, nicotine should be an illegal drug.

Congressman **Gilman**. But isn't that a good example of why we should not legalize and not decriminalize?

Mayor **Schmoke**. What it is a good example of——

Congressman **Gilman**. If we have a substance out there that should be controlled, then maybe we ought to be giving attention to controlling that substance.

Mayor **Schmoke**. We are. And we have decided to do it by the public health system. If we decided tomorrow or this Congress made cigarettes illegal, you are talking about a crime problem? There would be a massive crime problem, and we know that.

And so what we are saying is that we know that there is harm to the public out there, and we are going to try to deal with that harm through a public health strategy and through creating an environment of intolerance.

I mean, we have public buildings now where we are telling people that they can't smoke. We are having all kinds of anti-smoking efforts. But we don't make the sale of cigarettes illegal, because we know that would have an even more disastrous impact.

Congressman **Gilman**. I would be pleased to yield to the Chairman.

Chairman **Rangel**. Well, I would allow you to finish your questioning at this time.

Congressman **Gilman**. Well, I know that I have overextended my time, and I thank the gentleman for yielding. I thank the Mayor for yielding.

Chairman **Rangel**. The Congressman from New Jersey, Mr. Guarini?

Congressman **Guarini**. Mayor, while I admire what you are doing, there are certain things that are ringing in my ears that just don't make some sense. When you talk about tobacco and alcohol as an analogy, there is a lot we don't know about addiction.

And the addictions for cocaine or tobacco and alcohol don't seem to me to be of the same type or of the same level. And the intensity on them is much greater.

And, of course, we should do more research to find out how much more we can learn about addiction before we experiment with the lives of our young people because once we send out a message that it is okay to take cocaine and the message is a mixed message, how do we then get back to where we were before if we find out that the road we traveled was the wrong one?

And do we let farmers grow cocaine? You say it is going to be legal. Well, why shouldn't they be allowed to grow cocaine?

Chairman **Rangel**. Coca leaves.

Congressman **Guarini**. Or coca leaves. And then you have crack in the streets. There is where the crime is. Crack comes from cocaine. So how can you differentiate them?

And then when you talk about drugs, there are many. There will be hundreds of drugs. There will be many drugs in the laboratories. There will be designer drugs. It will be far more sophisticated. That will give it all kinds of legal questions as to what is a drug and what is not a drug and what is covered by law and what is not covered by the Schedule.

We are not really with enough basis in knowledge as to where we are going to make such a great step at this time.

Mayor **Schmoke**. Well, I agree with you, Congressman. That is why I am not advocating that we do this tomorrow. That is why I keep saying that I think that what I am trying to do is get us to focus in on our addict population now and to have this national commission that is going to look into all of these issues.

I think one of the things you said is very important. What is our goal? What is it that we are actually trying to achieve? Now, if we are trying to ban all substances that are harmful to our body, then we can't eliminate tobacco and alcohol from a consideration. Now, if we——

Congressman **Guarini**. But they are on different levels.

Mayor **Schmoke**. But they kill 400,000 people a year.

Congressman **Guarini**. They are different substances. They do different things to the body.

Mayor **Schmoke**. But you would agree with me on the statistics. They kill 400,000 people a year.

Congressman **Guarini**. That is the ultimate end. You can get killed 16 times, including riding in an airplane.

Mayor SCHMOKE. But the message we are sending to our children now is that we will tolerate a substance that involves slow death, but we won't tolerate a substance that will kill you quickly.

Congressman GUARINI.

Mayor SCHMOKE. If that is the message we want to send——

Congressman GUARINI. Well, as they say, two wrongs don't make a right.

Mayor SCHMOKE. Pardon?

Congressman GUARINI. As the old saying goes, two wrongs don't make a right. But we had troops in Vietnam——

Mayor SCHMOKE. But we have it within our power to try to correct it.

Congressman GUARINI. Yes. We had troops in Vietnam. That was almost free distribution. There were no drug lords. Everybody had it available to them. Our troops came back addicted, and they had readily available drugs.

Afghanistan, the Russian troops came back addicted. And I am sure that it was almost a free distribution where they had the plants and the drugs available to them.

Where would it be any different in a society where you say, "Okay. Instead of going out into the fields of Vietnam, go down into the dispensary and the drug store will have them for you"?

Mayor SCHMOKE. But that is not what I am saying, Congressman. That is why I try to keep emphasizing that I am not talking about just making it freely available to any person around to walk down to the dispensary.

I think we have to have an intolerant attitude, but I also think that what we have to do is come up with a better mechanism to control not only addiction, but the crime associated with drug trafficking. And nothing that we are doing now is controlling that crime.

Congressman GUARINI. Did you ever study the areas where there are societies that have less addiction, like Singapore and China? And the Prime Minister of Guyana was just in town, and I asked him the question, "Do you have an addiction problem there?" He says, "No. We have a transhipment problem, but we don't have an addiction problem."

There are societies that are free of it. Do we ask the question, "What are they doing right that we are not doing?"

Mayor SCHMOKE. China is probably the most repressive police state that we can think about, and if getting our drug problem down to the way China's is means we have to change our society, then——

Congressman GUARINI. Well, Singapore isn't.

Mayor SCHMOKE [continuing]. I am not interested.

Congressman GUARINI. Singapore is a democracy. Singapore isn't really a police state.

Mayor SCHMOKE. Well——

Congressman SCHEUER. Singapore has maintained the British system of punishment. They have the lash in Singapore that they inherited and that they maintain from the British.

Congressman GUARINI. Well, then, you are saying that punishment is, indeed, a deterrent to a crime?

Congressman **Scheuer**. Look, I can't speak for Mayor Schmoke, but it seems to me that if we want to approach Singapore, that Draconian level of punishment of 50 lashes and have no vision of a doctor, we are going to radically change the quality of our democracy.

Congressman **Guarini**. If that is the direction we go in, my good colleague, if we had a choice between killing our young people and putting the drug kings and the drug lords to the lash, I would choose the lash.

Mayor **Schmoke**. Congressman, I am not really against you. I am trying to work with you and not against you.

Congressman **Guarini**. I understand that.

Mayor **Schmoke**. And what I am saying is that if we can focus in on what are our goals in this effort and look at our present policies and say, "Are those policies achieving those goals?"; and "If not, is there anything else that we can do? Is there some other approach that could achieve those goals?" That is what I am trying to get at.

Congressman **Guarini**. Well, I understand your goals are noble, because we are all trying to get to the same direction. But bringing families together, giving jobs to our young people, giving them hope instead of despair, having social programs that make social sense, there is a direction we haven't gone in yet.

And perhaps those are the directions we should think of before we go and legalize drugs.

Mayor **Schmoke**. Well, in my written testimony, as the Chairman knows, those are the types of things that I also talk about.

Congressman **Guarini**. Thank you, Mr. Chairman.

Mayor **Master**. Mr. Chairman?

Chairman **Rangel**. Mr. Mayor?

Mayor **Master**. May I make a point on the topic of discussion?

Chairman **Rangel**. Yes.

Mayor **Master**. It is an interesting thing that the number of people who have written me—and the majority are from Texas and California—are absolutely abhorrent and will not even consider the legalization of drugs under any conditions, no way.

And then in the next paragraph, the only way to treat the user, the dispenser, the kingpins, kill them.

Chairman **Rangel**. Thank you for your contribution.

Mayor **Master**. Yes. It's great, you know.

Congressman **Guarini**. Do you mean all of the users, Mr. Mayor?

Mayor **Master**. These are the two extremes.

Chairman **Rangel**. We will send that to the commission as well.

Mayor **Master**. And in China, that is what they are doing.

Chairman **Rangel**. Thank you very much. Thank you.

Congressman **Guarini**. There are going to be a lot of dead people out there.

Congressman **Coughlin**. Thank you, Mr. Chairman.

With due respect, I couldn't disagree more with the mayor and with my colleague from California, Mr. Stark. As the Chairman pointed out, there is no one who says that legalization, even of marijuana, would not result in increased use.

In my opinion, if you have increased use of these substances, you have three potential consequences. One is the increased number of lives ruined as a result of drug use.

A second consequence that we have not discussed is the increased number of accident victims. We have had at least 37 railroad accidents involving drug use since the January 1987 crash that took the lives of 16 people at Chase, Maryland—37. These accidents occurred as a result of drug abuse.

Finally, we have not discussed the increased number of crime victims who fall prey to those who go out and rob in order to support their habit. I would also submit that certainly cigarettes and possibly alcohol do not turn people into the same kind of a zombie that will go out and rob and steal to support a habit.

Mayor SCHMOKE. If you made it criminal——

Congressman COUGHLIN. These are additional consequences of your legalization program that haven't been taken into account.

Mayor SCHMOKE. Well, I think that we have addressed that, and the suggestion is that decriminalization would reduce the amount of crime because people would not have the incentive to break into houses to steal in order to get the kind of money that is necessary now to satisfy drug——

Congressman COUGHLIN. You would still have to have money to buy the drugs.

Mayor SCHMOKE. Pardon?

Congressman COUGHLIN. Even if the drugs were legalized, you would still have to have money to buy them.

Mayor SCHMOKE. Now, I would say under a public health approach, if there is a poor person who goes to a physician or a clinic, that we should dispense it the way we would dispense drugs to poor people now, which is through Medicaid.

Congressman COUGHLIN. Medicaid?

Congressman OXLEY. Will the gentleman yield?

Congressman COUGHLIN. Yes.

Congressman OXLEY. Will the gentleman yield just briefly?

Congressman COUGHLIN. Certainly.

Congressman OXLEY. Mr. Mayor, you are saying that the taxpayer should pay for illegal drugs?

Mayor SCHMOKE. No, sir. I am saying that the taxpayers are paying a heavy price now and getting nothing for it.

Congressman OXLEY. Who would pay for those drugs that were dispensed?

Mayor SCHMOKE. The public health system, sir.

Congressman OXLEY. Where do they get their money?

Mayor SCHMOKE. But you are saying "illegal." It would not be illegal. It would be a substance which a physician, in dealing with his patient, could decide that it is important to maintain that patient on this substance of abuse.

Congressman OXLEY. Well, your public health system gets its money from the taxpayers, doesn't it?

Mayor SCHMOKE. Yes, sir.

Congressman COUGHLIN. Can I take my time back?

Mayor SCHMOKE. It would be——

Congressman COUGHLIN. I guess I don't——

Mayor SCHMOKE. It would be a medicine.

Congressman COUGHLIN. I would——

Mayor SCHMOKE. But it wouldn't be an illegal substance.

Congressman **Coughlin**. I would ask the Mayor, do you really believe that legalization of marijuana would not result in more accidents on our highways and railroads?

Mayor **Schmoke**. I don't agree with you that the evidence indicates that decriminalizing marijuana increases use. In fact, the statistics—I mean, we can argue statistics all day, but the data that I have seen from the places that have done it, the use has not increased. And would——

Congressman **Coughlin**. I would certainly like to see that data, because I have never seen anything——

Mayor **Schmoke**. Oh, I'm sure we have people who are more astute on this issue——

Congressman **Coughlin** [continuing]. That indicates that legalization does not result in increased use.

Mayor **Schmoke**. Yes. Well, there are other people coming in later panels that have studied this for a number of years. And I have just read their material on that.

Congressman **Guarini**. Would the gentleman yield?

Congressman **Coughlin**. Why don't we give the other members an opportunity to share their views on this matter?

Congressman **Guarini**. Yes. I just want to bring up one point that was brought to me by the staff. The nine-month studies indicates that out of 1,023 patients studied, 34.7 percent were found to have used marijuana within four hours of admission to the center. And I think that is significant to show that car accidents are, indeed, caused in great part by the immediate use of marijuana and drugs.

Mayor **Schmoke**. But, Congressman——

Chairman **Rangel**. I would want really to finish this panel. So what I am going to do is move on with the five-minute rule, allow the members of the Committee to inquire first, and then go to those members that are sitting with us.

The Chair yields to Mr. Ortiz.

Congressman **Ortiz**. Thank you, Mr. Chairman.

One thing that disturbs me is about the young people. We are talking about them experimenting with drugs. How are we going to treat the 13 or 14 year old girl or young boy who decides that he wants to experiment, and he experiments, and then he likes the drugs?

Mayor **Schmoke**. You're just describing life in present day America.

Congressman **Ortiz**. Well, let me go further. But it has become legalized.

Mayor **Schmoke**. Congressman, availability is not an issue, is it? I mean, it is already out there excessively——

Congressman **Ortiz**. My next question is: At what point will you say that an individual is addicted? What criteria will you use for the young one to say, "At this point he is an addict," he becomes available to come into a clinic or a hospital and receive drugs?

Mayor **Schmoke**. I would allow the medical professionals to make that judgment. Congressman, I am not saying that we would allow access to children or promote access to children.

What I want to have are additional resources into this whole "Say No" program to have an intolerant attitude by our country about drug use and to try to protect the children. But right now, they are getting access to these substances.

Congressman Ortiz. Right. But I am going a step further. Let's say that we are sending the wrong signals and they say, "Well, if it is legalized or decriminalized, it is good."

So he goes to the underworld, he goes to the black market to obtain the drugs, and he likes it. And then he says, "I can get it free."

At what point are we going to determine that he qualifies at a young age because he went to the underworld and obtained it and liked it, now he's getting it free?

Mayor Schmoke. I may not be following you there, but the point that I have tried to make is that we are not saying to him that it is good. I mean, right now there is alcohol in our society that is legal. I don't think we are saying to 10, 12, 13 year old children that alcohol is good; nor are we trying to promote the sale of those substances to those children.

And if there is a young alcoholic, we treat that alcoholic for that disease of alcoholism.

Congressman Ortiz. But not with alcohol.

Mayor Schmoke. We treat him with whatever, but——

Congressman Ortiz. But you don't give an alcoholic alcohol.

Mayor Schmoke. Congressman, as I indicated from Dr. Klieber's testimony, the most important way of beginning to treat a heroin addict is not to make him go "cold turkey," but to actually give him that substance, maintain him on that substance as you wean him off.

Obviously, if a person has one disease, you are not going to treat him the way you would treat him for a separate disease. I think that the public health professionals will tell you that it is important to maintain these addicts on the substance while you are trying to treat them.

But they can't do it now because of the way our criminal law is written.

Chairman Rangel. If you will pause for a minute, Mr. Mayor, let me confer with the members of this Committee. We had indicated earlier that we were going to break. Obviously, we are past that point now.

There is a Conference Report on legislation that is on the floor. I don't know how much time Mayor Schmoke and our distinguished Mayor has from West Virginia, but it would be the Chair's intention to vote and to break until 1:00 o'clock.

May I inquire as to whether or not the members of this panel would want to further question Mayor Schmoke and, if so, whether or not he would be available at 1:00 o'clock?

Would there be any questions at 1:00 in order to ask him to return?

Congressman Scheuer. Mr. Chairman, I would be willing if Mayor Schmoke is not going to be available then to agree not to ask questions now, but I would ask unanimous consent that we can address questions to all of the witnesses by mail and hold the record open.

Chairman **Rangel**. The record will be open for additional questions and perhaps we can make public some of those questions in order to expand the so-called "discussion."

Mayor Schmoke, let me thank you for——

Congressman **Oxley**. Mr. Chairman? Mr. Chairman?

Chairman **Rangel**. I am sorry.

Congressman **Oxley**. Mr. Chairman, I also had some questions for the Mayor that I would love to propound if that is doable, either now or——

Chairman **Rangel**. At 1:00 o'clock?

Congressman **Oxley**. I would be willing to be here at 1:00 o'clock. I don't know what the——

Chairman **Rangel**. Well, the question is that we do have a vote. We would have to break, anyway, for lunch.

Will you be available at 1:00 o'clock?

Mayor **Schmoke**. I will not, Congressman. The problem is that I am supposed today to go visit one of our sister cities in Spain. The fact that I am leaving the country has nothing to do with my appearance here today, but I have to go fly up to New York.

Chairman **Rangel**. We hope that the questions will follow you to Spain.

Mayor **Schmoke**. Thank you.

Chairman **Rangel**. And we will continue. Why don't you just take over the Chair? I yield to Mr. Oxley. I am going to vote. And then you could recess until 1:00 o'clock for us.

Congressman **Mfume**. If the gentleman would yield for just a moment, the Chair?

Congressman **Oxley**. Mr. Mfume?

Congressman **Mfume**. I am going to leave with the rest of the panel also to vote, and I may not have an opportunity to see the Mayor before he leaves. But I certainly want to thank him. As I said in my opening remarks, I consider him a friend and a colleague. We both represent many of the same people in Baltimore.

This was a daring issue to go out on in terms of the leadership, and he is there to do that. He, in many respects, is responsible for all of us being here today to grapple with this very same issue. And although we have differences of opinion, I think we all have in mind the same goal.

So, Mayor Schmoke, I want to thank you again for journeying here to be with us, but even more so for daring to raise this issue for debate. And I agree with what was said previously. I think our democracy is strong enough to deal with this debate and to become a better nation for it.

Thank you very much.

Mayor **Schmoke**. Thank you, Congressman.

Congressman **Oxley**. I thank the gentleman from Maryland, and I particularly appreciate both Mayors remaining just a little longer. And I will miss the activities on the House floor because I think this issue is as important as any legislative matter this Congress has considered.

Mayor Schmoke, do you distinguish between the addict and the casual user?

Mayor **Schmoke**. Yes, sir.

Congressman OXLEY. And would you concede that there are literally thousands and thousands of casual users? And, if, in fact, you plan to provide the kind of medicinal help that you describe to the addict, what happens to the casual user? What happens to the so-called "yuppie" that buys a glisson of cocaine for a weekend recreational use? How does he fit into this plan that you proposed?

Mayor SCHMOKE. Well, as I said, I am talking about the beginning. Where we end up ultimately would be decided by this commission. But right now that person would still be in violation of the law and would still be subject to prosecution at the initial stage.

Congressman OXLEY. So, in other words, we are going to have a self-professed addict, who will be able to go to a hospital and receive a fix on demand, and at the same time we are going to make that casual user a criminal, who would be prosecuted?

Mayor SCHMOKE. No. What I am saying to you is that I am trying to get that addict, trying to keep that addict from breaking into your house or shooting you on the street in order to get money to go deal with the criminal.

Congressman OXLEY. Well, where does the money that the casual user spends go? Doesn't that go ultimately to the drug kingpins?

Mayor SCHMOKE. Well, let's look at the situation that we have right now and try to figure out exactly how we stop that casual user from going to the drug kingpins now. And I don't think we have been able to do that at all.

What I am trying to do is to put the drug kingpins out of business by taking a big portion of his market, which is the addicted population, and take them and pull them into the public health system.

Congressman OXLEY. Mayor Master, did you have a comment on the previous question?

Mayor MASTER. My point is that 25 grams of pure cocaine costs the hospital less than $200. Now, they cut it with lactose powder and sell it on the street for over $10,000.

And I think that we in public service, in the public health departments can afford that expense when it is that low.

Congressman OXLEY. What percentage of your taxpayers in West Virginia would be willing to use their tax dollars to support drug addicts?

Mayor MASTER. Ten percent.

Congressman OXLEY. That high?

Mayor MASTER. That low.

Congressman OXLEY. How about you, Mr. Schmoke?

Mayor SCHMOKE. Well, I think that at this point probably an overwhelming number of people, nobody wants to support it.

Congressman OXLEY. That is right.

Mayor SCHMOKE. What I am trying to get people to understand is that they are paying a terribly high cost now and not receiving many benefits from the current approach.

And the question is: After we take a look and do the research and have the debate and we present them with a situation that is a much more flexible approach, we would be able to say to the public, "Would you like to reduce your crime rates by trying this way rather than staying with the current approach?"

And I think that after people hear about this issue and understand it, that more people would opt for a more flexible approach than the rigid approach we have now.

Congressman OXLEY. How many votes do you think you have got in the Congress for your proposal?

Mayor SCHMOKE. If the idea is to immediately decriminalize?

Congressman OXLEY. Yes.

Mayor SCHMOKE. Is there a negative vote that could be cast?

Congressman OXLEY. A nodding one.

Mayor SCHMOKE. I don't think that I in any way have a majority or anywhere close to that of people who would be in favor of this, but what I am saying is that I think that if they ask the questions, "Have we won the war against drugs?"; most people would say "No." Are current strategies winning? No. Is doing more of the same going to win? No.

And if we answer "No" to those questions, I think there are a lot of people that want to open up the debate to considering alternatives, and I do think this is one alternative that would lead to a better country.

Congressman OXLEY. Mayor, at what point do you think anybody could safely say that we have successfully fought and won the war on drugs? Where are you willing to draw that line?

Mayor. SCHMOKE. Well, we have been doing this for 74 years. Now, if we were fighting any other war for 74 years and had this kind of a lack of results, I would think we would not only want new generals, but we would want a new strategy.

Congressman OXLEY. And is there some point where you think we could reach to say that we have a drug-free America?

Mayor SCHMOKE. Oh, no. Certainly we don't have a drug-free America now, but we have to look back at our history and say, "Look, we tried to have an alcohol-free America," and we were having success at reducing the alcoholism rates.

But look at the costs that we were paying in terms of an overrun criminal justice system, terror in our streets, young children being used as lookouts for bootleggers and adulterated alcohol flowing through the veins of the people in our communities.

I mean, it is a question of what costs are we willing to pay in order to reach this goal that you are talking about.

Congressman OXLEY. If I could, just one more question for Mayor Master. You had indicated in your testimony, as I recall, that there should be absolutely no debate about legalization or decriminalization of mind-altering drugs, L.S.D., P.C.P., and so forth. But I got less than a firm answer, I think, in regard to cocaine and heroin, that at least you were willing to look into that.

How can you distinguish, and how do you distinguish between mind-altering drugs, like P.C.P. and heroin and cocaine?

Mayor MASTER. I don't. It is just a personal opinion.

Congressman OXLEY. Well, why should we have——

Mayor MASTER. Just a gut reaction.

Congressman OXLEY. So, basically, you are saying we should really not even argue about decriminalization, legalization, not only for mind-altering drugs, but for cocaine and heroin?

Mayor MASTER. That seems to be where the problem is as far as the criminal element is concerned, and that is what is bothering us.

Congressman OXLEY. Well, it seemed to me a bit inconsistent that——

Mayor MASTER. Well, do you find L.S.D. and P.C.P. on the streets with these criminals, too? We haven't. We found cocaine, crack, and pot.

Congressman OXLEY. In the District of Columbia, as a matter of fact, and I'm sorry that Mayor Barry had to leave, but that clearly has been the case.

Let me now turn to a friend from Florida, Mr. Shaw, for some questions, and we will try to wrap this up, because I know you both have commitments.

Congressman SHAW. Thank you, Mr. Oxley. Having been a former Mayor myself, having been three times the Mayor of the City of Fort Lauderdale, I know the frustration that is vibrating from this witness table.

Mayors do not go off and leave their constituents and leave for Washington. They live with their problems day and night, and they are on call 24 hours a day, if they are going to do a good job.

So I can understand this frustration, but I think that we have totally ignored the fact that we do have a choice. The frustration of a mayor is because the supply is out there, and there is not a thing he can do about it because it keeps flowing in from the outside.

And the problem with our national drug policy is that we are not doing anything except working around the perimeter.

Mayor Master, you made a parallel a while ago on the question in Vietnam, or you brought that up. And I think if you look into what happened in Vietnam—and there is a lot of us that believe that we did not have a will to win; we had a will only to contain, and that is why we got beat.

Mayor MASTER. Right.

Congressman SHAW. And that is why we lost. And that is why we are losing the war on drugs here in this country. We are satisfied only to contain it.

Mayor MASTER. Absolutely.

Congressman SHAW. You never had a war without going into the source and taking it out.

Mayor MASTER. We lost the war in Vietnam. We are a country that hates to admit defeat. We have lost the war on drugs. We hate to admit that defeat.

But it is here, and it is now, and unless we use atomic power (if we had in Vietnam), but we're not. We're containing it. We've got to use the "atomic power," quote, unquote, on this war on drugs.

Congressman SHAW. Let me finish where I am coming from.

Obviously, Mayor Schmoke, in looking at your distinguished career, and obviously you are a man of great intelligence. I can tell that just by the way your demeanor is here before this Committee.

If I were to tell you or if you were to believe that we could wipe out the sources of cocaine, the sources of other agricultural products that are producing these drugs, would you want to go forward with any type of plan such as you had set forth?

Mayor **Schmoke**. You are saying if we could eliminate drugs from the face of the earth?

Congressman **Shaw**. Yes, sir.

Mayor **Schmoke**. Well, then, obviously, I wouldn't be here.

Mayor **Master**. That is right.

Congressman **Shaw**. We can. We just sent a spaceship up into space today, and we can from space, we pinpoint where every cocaine leaf is on the face of this earth that is growing out in the sunshine. We can do it. We also had herbicides that can knock them out. We can do it.

The problem that we are having is that we are not getting the right type of cooperation from these other countries. The cocaine fields in Bolivia are a greater threat to the future of America than all of the Soviet missiles around the globe.

And I believe that it is necessary for us to go out and take them out, allow these countries to again take control of their own borders, to assist them in wiping out these cocaine fields and marijuana fields. And if they do not welcome our assistance, then take them out, period. That is a choice that I believe that this country is going to have to take.

Now I see some heads shaking here, but I will bet you tomorrow, I will bet you today that if we put it to the American people that we are going to eliminate these cocaine fields around the globe, that we will have them rallying around behind us just like we did when we went in and took out some Soviet airfields in Grenada. There is no question about it.

And that is what is going to do away with the frustration that I am seeing of mayors all over this country. We had tried interdiction. We had done a brilliant job of interdiction. But interdiction alone is not going to work.

Mayor **Master**. May I offer another suggestion? In my testimony, rather than, as you suggest, doing it in a democratic way, by not invading those countries and killing those crops, is that all foreign, military, and/or domestic aid to countries, Bolivia, Peru, Venezuela, Colombia, Panama, Mexico, Turkey, India, you name them, any of those countries that produce any drugs at all, cut them off all funding!

Congressman **Shaw**. I believe——

Mayor **Master**. You can put the ball in their court, and they're going to have to handle it or they're going to get cut off altogether.

Congressman **Shaw**. I believe strongly that we should use everything available to put pressure on these countries to ask for our assistance. I agree with that. And economic pressure of all types is certainly well within our grasp.

Mayor **Schmoke**. Congressman, it is just simply my view that I think that if what we are saying is that the only way to win this war on drugs is, for example, to invade our allies and——

Congressman **Shaw**. Well, I'm not talking about an invasion of any great proportion. I am talking about simply going in and putting the herbicides on the fields.

Mayor **Schmoke**. I would just simply say that I think that if that is one option, then it ought to be viewed in the context and put up to the mirror and looked at with other options, too. And that is all I am saying.

You are asking for a new strategy. I am calling for a new strategy. And I think that it really will take some more discussion, research, then put it to the American public that this is what we think is actually going to be successful in solving this problem.

And I am not sure that they would go with your approach. Obviously, at this point, they are not going to go with mine, but I think that we may be able to come out with some compromise position that is closer to a public health model than to a criminal justice model.

Congressman SHAW. Well——

Mayor MASTER. I'm a veterinarian. It concerns me when you talk about using the pesticides.

Congressman SHAW. I'm not talking about pesticides. I said "herbicides."

Mayor MASTER. Herbicides, Agent Orange, Liquid——

Congressman SHAW. Let me tell you something, sir, Mr. Mayor, that the type of pesticides that these marijuana producers, cocaine producers are using is out of our hands. And they are using the pesticides. They are using it.

They are killing game in our national parks——

Mayor MASTER. I know.

Congressman SHAW [continuing]. Throughout our country by the use of these pesticides.

Mayor MASTER. That is why I am opposed. Agent Orange?

Congressman SHAW. I am talking about a herbicide which does not kill animal. It just kills the vegetation. And I am talking about working through the United Nations, working through the Organization of American States to bring pressure on these countries, do everything we can to bring pressure on these countries.

But what I am also talking about is providing a means by which these countries can again regain control of their own borders. Parts of Colombia, Bolivia, Peru are completely outside of their governments' control.

We are talking about assisting Colombia, who is right now struggling to try to regain control of its own borders. What is going on is getting continuously worse, and it has to be checked. And we are going to have to check it. Either that or we are going to lose the future of this country. And legalization is surrender, and surrender is totally unacceptable.

Thank you.

Congressman OXLEY. All right, I thank the gentleman from Florida. And at this time, I would like to thank both Mayors for sticking around the entire hearing and being with us and for their testimony.

The Committee will stand in recess until 1:00 p.m., and I ask that the room be cleared so that the afternoon session can admit some people who have been waiting all morning to get in.

Again, thank you. And we will recess.

Mayor MASTER. Thank you, Congressman.

Mayor SCHMOKE. Thank you.

[Whereupon, at 12:45 p.m., the Committee recessed, to reconvene at 1:00 p.m. the same day.]

AFTERNOON SESSION

Chairman **Rangel**. The Chair apologizes. We have a number of members of Congress that were leaving the New York delegation. I am certain that the Mayor is aware of that, but we are anxious to get started. And why don't we lead off with Mayor Koch, who has been a great advocate of more federal resources being made available as we attempt to deal with the questions of interdiction, eradication, health care, education, prevention, and certainly law enforcement.

And we will start off with you.

TESTIMONY OF THE HONORABLE EDWARD I. KOCH, MAYOR, NEW YORK CITY, NY

Mayor **Koch**. Thank you very much, Mr. Chairman. I am not going to address those issues that you just addressed, because I know there are time restraints. And I am going to limit myself to dealing with Mayor Schmoke's proposal, which effectively would decriminalize drugs, or at least initially have a national commission to decide whether they should be legalized.

He doesn't draw a real distinction between decriminalization and legalization, because, for him, decriminalization means having it dispensed by doctors. I gather from that that legalization means it being dispensed in stores. That is what I drew from his testimony.

If I am wrong, I obviously would like to be corrected. But I think that is really what he was saying. He is a brilliant spokesman for a bad idea. I want to tell you why it is a bad idea, although I know you already know.

The fact is that it is not a new idea. I mean, people sat at this table as though they had just invented the wheel. That particular wheel, which was a flat wheel, was tried in Great Britain. It began in the '60s and was abolished in 1985.

And the very proposal about which Mayor Schmoke went into in great detail was exactly what was tried in Britain, where they said, "Let the doctors prescribe." And as soon as the doctors prescribed, the addict population doubled.

And then they took it away from the doctors because they said they couldn't trust the doctors. And then the British Government went into the business of dispensing through clinics. And the population quadrupled. And crime went up.

So the two things which Mayor Schmoke and his supporters have alleged might be positively addressed, addiction and the spread of addiction, law enforcement and crime both turned out to have negative aspects when the proposal which he is now advocating was, in fact, tried in Great Britain. They abolished it in 1985.

Now let me tell you why it cannot work. He says, Mayor Schmoke, "Well, I would decriminalize, meaning allow doctors to prescribe heroin and cocaine." He was pressed here by some of the members. Would you allow crack? "Oh, no." Why not? That question was not asked.

And it is because everybody knows that crack is now the drug of choice. And everybody knows that it induces violent behavior. And everybody knows that kids are on it. So it would not serve one's purpose advocating "decriminalization," as he puts it, for other substances, to include crack, P.C.P., or anything else.

Now what someone should have asked Mayor Schmoke is: Do you know, theoretically, how crack is made? Crack is made from cocaine. And one of the law enforcement agents, while we were eating our tuna fish sandwiches back there, said to me, "I'm going to tell you, Mayor, how it is made. You take cocaine, and you put it in water. And then you have to have some other base," baking powder or something, I guess, "and then you heat it. And then there are pellets. And the only difference between the powder before," which I guess you snort it, "and now is that you can smoke it."

So what does Mayor Schmoke think, that these crackheads don't know? They don't know you go in and you get your cocaine, and how to turn it into crack? This is begging the issue not to discuss it.

And let's assume that there were some way to control it, which I doubt. You don't think that if there is a private demand, that the mob, organized crime wouldn't be out there supplying that demand?

I will tell you what they did in Great Britain. This is a statistic that Great Britain put out. Eighty-four percent of the addicts registered with the Government were found to use other illicit drugs as well.

Do you think that we are different here? I believe that people are constantly looking for new highs, new ways to get high. And if cocaine is freely available, well, then that is not the way to get high any more. You want something more exotic.

Crack is not available? We will turn it into crack. Crack becomes available? We will get some other designer drug. It is a bad idea.

And then I will go to a secondary aspect. You say to anyone who advocates—it is really legalization, but they like to call it "decriminalization," because if you say the doctors can dispense it, that's not decriminalization; that is legalization.

The distinction they make, I will repeat, is you are not going to give it out at the store; you are just going to give it out at the doctor's office. Okay. What happens to youngsters? Now, immediately, if you put that question to someone at this table who was for legalization, they are going to say, "Of course, you can't give it to a youngster."

Let's assume a youngster means someone under 17 or 18, whatever it is. But we have youngsters as young as 11 years old just apprehended on Long Island who were wholesalers, selling it. They were probably using it. I don't know in this particular case, but I assume so. But we know that there are 11, 12, 13 year old kids who are on crack. And it is a mind-changing drug that causes violence.

Well, what do you think organized crime is going to do? Organized crime is going to say, "You can't get it at the doctor's office? You can't get it at the store? Come to us." It is only $3 a vial in New York City, is my understanding. So it is not a question of money any more.

People aren't necessarily—although many people are because they have criminal personalities or crack creates criminal personalities—stealing to get the $3. Some undoubtedly are because they want to be on crack all day. But others are able to afford it.

And don't you think that organized crime is going to provide that resource? I think it will. Will it provide the other illicit drugs to the adults? And now you get to the bottom line, which will then end it for me, unless you have questions for me, of course.

The imprimatur of acceptability. Thank God in this country the taking of drugs is still perceived to be bad news. We have 500,000 heroin addicts estimated by the federal government, 200,000 of them being in the City of New York.

We have 6 million cocaine addicts. I have not seen the breakdown for the City. We have about 240 million people. So as of this moment, it is not exactly a majority position to take drugs.

What do you think will happen when the imprimatur of lawfulness, acceptability is there? Well, people will say, "Listen, if the Government now says it is okay, it can't be all that bad. If the Government is either allowing doctors to give it out or giving it out at the stores themselves, it can't be that bad." It is very bad.

Now, when they say, "We will not let children have it," and, of course, they point to cigarettes and alcohol for different purposes, I think we made a mistake. So shall we repeat the mistake?

Let's put it right on the table. People ought not to smoke. And, in fact, after an educational campaign of I don't know, 30, 40 years, middle class people are not smoking any more. You go to any dinner party, you rarely find someone who is smoking.

It is, regrettably, those who are on the bottom of the economic ladder that education has not yet influenced adequately who are still smoking the largest number. That is regrettable. But how long did it take before it set in that smoking is bad for you?

Now, as it relates to liquor, we made a mistake. I don't know how we could have done it better or whether we could have found a way to have prohibition.

But let's not repeat that mistake. It was a mistake to allow liquor to flower as it did, but it is there. And I don't know. I am going to leave it to other people to comment on whether something can be done educationally.

But at this point to have a third error and to rely on education, which we know will take 20 years before it has any impact at all, which is why interdiction is so important at this particular moment?

And, therefore, I believe that Mayor Schmoke, who I want to accord high points for brilliance and intelligence, is on the wrong track. And I think that it makes no sense at all to commence what he proposes in two steps: decriminalization, meaning letting doctors dispense it; and then a commission to decide whether it should be legalized, meaning sold at the stores. I am against either.

Thank you, Mr. Chairman.

[Statement of Mayor Koch appears on p. 231.]

Chairman RANGEL. Mayor Koch, you know better than most witnesses that these bells are once again asking us to respond to the floor to vote. Let me ask, would you have time to stay until we get back?

Mayor KOCH. Yes, I will. Of course.

Chairman RANGEL. Then one of the questions I would have at the appropriate time is to see how you can take the position you do, and I agree with you on, and still believe that we should try sterilized needles.

Mayor KOCH. I thought you would ask me that. I came well prepared.

Chairman RANGEL. Very good.

[Recess.]

Chairman RANGEL. Mayor Koch, I think you were concluding with how the distribution of legalized sterile needles was different.

Mayor KOCH. Shall I tell you what we are doing right now?

Chairman RANGEL. Yes. And then we will go on to the next witness.

Mayor KOCH. In the City of New York, we have 1,400 A.I.D.S. patients as compared with San Francisco, which has 140. We now have 25 percent of all of the A.I.D.S. patients in the whole country. It is actually going down.

And what is important to know is that the spread of A.I.D.S. amongst homosexuals is reduced and the increase now is amongst intravenous drug users, and the largest number of intravenous drug users who have A.I.D.S. and where the spread is occurring is amongst Blacks and Hispanics. That is the largest number.

And 1,700 women have been diagnosed in the City of New York as having A.I.D.S., and 90 percent of them are minority. And 300 children have been born in the City of New York who have A.I.D.S. because their mother was a drug addict or because their mother slept with a drug addict who passed A.I.D.S. onto her. They will all die. That is the general belief.

Now, three doctors, Dr. David Sensor, the Health Commissioner of the City of New York a number of years ago, an outstanding doctor of public medicine, came up with the original idea. He said, "Let's see whether we can stop the spread of A.I.D.S. by exchanging needles, because A.I.D.S. is spread from one drug addict to another through a dirty needle," meaning blood from a contaminated addict to a noncontaminated addict.

Chairman RANGEL. No, it's not a new concept. I just wondered how you differentiated that——

Mayor KOCH. I'm going to.

Chairman RANGEL [continuing]. With Mayor Schmoke's——

Mayor KOCH. I will. I am going to. I mean, I don't want to take too much time, but I have to explain it if it is to have any relevancy. But I will try to be briefer.

First, there are only 11 states in the whole union that require prescriptions for needles. In 39 states, you walk into a drug store, you buy a needle.

Secondly, statistically, many of the states, where needles require a prescription, have the largest incidence of A.I.D.S., and the states where you can buy a needle, walking into a store and buying it for I don't know, a needle wholesale costs about 20 cents and $5 on the black market, that they have a lesser spread of A.I.D.S. in this particular population.

So Dr. David Sensor said, "Why don't we try a small experiment?" And he came to me, and he said, "Would you support it?"

It does not require a change in the law; it requires the State Health Commissioner to agree, and it is very small.

So I said, "Well, I will send letters to all of the law enforcement people and see what they say." And they all sent me letters back. And Sterling Johnson is here, and I'm sure he will tell you later, if you ask him, what he said to me then.

"No, don't do it." And all the law enforcement people said it, and the reasons they gave are very simple, that the cult of heroin use is to exchange needles. And it puts the imprimatur of the Government on the drug trade if you exchange the needles. Those are the two reasons.

"So," I said, "this isn't going any place, David, if all the law enforcement people are against it." He said, "Mayor, they are wrong. All we want to do is to do it with 200 people. We have 200,000 drug addicts. And if we are right, we will save lives." Well, the idea died.

And then Dr. Steven Joseph came in, also a world-renowned public health doctor, and he said, "Sensor was right. We should do it, Mayor. Let me submit the application to Dr. David Axelrod," who was the State Health Commissioner.

They submitted it, and he said, "Yes." Now, what is involved here? 200 people who can only get into this "cohort," I think they call it, if they are on a waiting list to get into a drug treatment program.

And while they are waiting, they will get counseling. They will be the first of all the people out there to get into the first slots that come in. And there will be a second cohort of 200 that will simply be analyzed on a regular basis to see whether there is a change in the seropositive conversion rate as to non-A.I.D.S. or non-H.I.V.

And, say, these three doctors, Axelrod, Sensor, Joseph, and a national medical association, but I don't want to give it by name, that say, "Yes, we should try it."

Now, assume that it doesn't work. What have we done at the end of a reasonable period? It is not like Mayor Schmoke, who says, "Give every addict who is taking heroin his heroin or his cocaine by going into a doctor's office."

It is the National Academy of Sciences, the Surgeon General, the World Health Organization all endorse this idea. Who gave me this wonderful list?

Chairman RANGEL. Okay. Well, that is really terrific, and we would want all of the additional information on this subject.

Mayor KOCH. That is why we are doing it. If it doesn't work, we will end it.

Chairman RANGEL. Okay.

Mayor KOCH. But assume that it works, we may be saving lives.

Chairman RANGEL. You know, the last time we discussed this, I asked you a question, and that was whether or not there was any treatment related at all to this program of——

Mayor KOCH. They get counseling.

Chairman RANGEL. Okay.

Mayor KOCH. They get counseling and——

Chairman RANGEL. And you told me not to your knowledge. But today you said that it is really for people who are going to be selected who are waiting for treatment.

Mayor KOCH. Correct.

Chairman RANGEL. Well, the question I was asking you then was that you were saying, then, you wanted to determine with one control group——

Mayor KOCH. Yes.

Chairman RANGEL [continuing]. Whether or not it would be less activities as related to the A.I.D.S. virus with the sterile needle as opposed to the uncontrolled group.

Mayor KOCH. Correct.

Chairman RANGEL. Now if what you are saying is that the controlled group is awaiting treatment——

Mayor KOCH. That is correct.

Chairman RANGEL [continuing]. Then I assume that treatment means that you are trying to get them off of drugs?

Mayor KOCH. They are counseled to get off drugs, this cohort of 200.

Chairman RANGEL. So if you are successful in getting them off of drugs——

Mayor KOCH. Wonderful.

Chairman RANGEL [continuing]. Then you don't have any control group and the whole idea just goes down the drain.

Mayor KOCH. First of all, let me just respond.

Chairman RANGEL. You don't have anybody.

Mayor KOCH. I am not a medical statistician. I'm not even a regular statistician.

Chairman RANGEL. Well, I am not either. But we are just trying to learn from each other.

Mayor KOCH. But this is a very exact science, and if the——

Chairman RANGEL. Not giving away needles. That is easy.

Mayor KOCH. Yes, sir, it is.

Chairman RANGEL. That is not a science.

Mayor KOCH. The science is the controls. And if these three doctors and these other groups, which I won't re-mention, believe it is worth doing, which is totally different than your basic question, which is that is this any different than Mayor Schmoke's proposal—you bet it is.

Chairman RANGEL. Mayor Koch?

Mayor. KOCH. We are just talking about 200 people, not 6 million.

Chairman RANGEL. Mayor Schmoke has recommended to us a half a dozen outstanding physicians and Ph.D.s that would follow this panel.

Mayor KOCH. Yes.

Chairman RANGEL. And if that is the kind of advice that you are following as relates to sterilized needles, I hope that your time would permit you to hear from them, because they have got a case to make.

Mr. Gilman?

Congressman GILMAN. One question, Mayor, and I will be brief. We hear quite a bit of comment that by legalizing, we will get rid of the criminal element, we will get rid of crime. What are your comments about that?

Mayor KOCH. I think it is a foolish philosophy to think that you are going to reduce crime, and the experience in Great Britain is that crime went up.

Congressman GILMAN. You visited the Netherlands, I think, not too long ago.

Mayor KOCH. Yes. And people misquote what they do in the Netherlands. In the Netherlands, in old Amsterdam, the fact is that cocaine and heroin are strictly prohibited, and you are arrested for possession or sale.

They do have a policy, which they are really very sensitive about, which is that they will not direct law enforcement against marijuana sales, which are open and notorious there, because they don't have the resources to address all at one time.

But when they get through with controlling, if they ever do, the harder substances, it is my understanding that they will then seek to control marijuana.

I thought that it was a mistake to give it the original imprimatur.

Congressman GILMAN. And did you have an opportunity to discuss with any of the Amsterdam officials about the crime rate, whether it has been up or down because of that?

Mayor KOCH. I don't know what the crime rate is.

Congressman GILMAN. Thank you. No further questions.

Chairman RANGEL. Mr. Scheuer?

Congressman SCHEUER. Well, it's a great pleasure to have our Mayor down here, one of the great mayors in the history of New York. Don't shrug, Eddie. It's the truth. Own up to it.

Mayor KOCH. Well, only one out of three in New York believe that.

Congressman SCHEUER. Well, I believe it, and if they were around long enough to see how you saved the City from absolute financial chaos——

Mayor KOCH. Thank you.

Congressman SCHEUER [continuing]. A decade ago, they would understand it.

Mr. Mayor, you seem to be in favor of provision of free needles.

Mayor KOCH. As a test.

Congressman SCHEUER. As a test; right. And you seem to feel that the counseling helps, that the counseling——

Mayor KOCH. Yes. It gets them off of drugs.

Congressman SCHEUER. To get them off of drugs; right. Now, I haven't endorsed legalization or decriminalization. In fact, I hate to use those two words, the "L" word and the "D" word. But, arguendo, Kurt Schmoke does, and he makes to me at least a compelling enough case that we ought to study it and bring in experts and think about it.

Mayor KOCH. It has been studied already.

Congressman SCHEUER. Eddie, let me ask you my question. You rely on the counseling that is a component of the provision of free needles as perhaps getting them off drugs.

Why do you feel that the counseling which surely is a part of the provision of drugs under, let's say, some kind of test program of decriminalization, or what have you, why do you assume that counseling when these addicts——

Mayor KOCH. Let me get——

Congressman SCHEUER. Hold on. Let me finish the question. When they surfaced, one of the advantages of some kind of an experimentation of that kind is addicts surface. They become visible, and we can treat with them. We can talk with them. Why do you assume that——

Mayor KOCH. I will tell you why.

Congressman SCHEUER [continuing]. Drug education——

Mayor KOCH. Easy.

Congressman SCHEUER [continuing]. And counseling would work——

Mayor KOCH. I will tell you why.

Congressman SCHEUER [continuing]. In the case of free needles, but not in the case of addicts.

Mayor KOCH. I will tell you why.

Congressman SCHEUER. Tell me why.

Mayor KOCH. Because in order to get into that small cohort of 200 people out of 200,000 who are heroin addicts in the City of New York, you have to be one of those who has signed up for treatment.

Now, that is not what—you are not going to give heroin and cocaine, under Mayor Schmoke's proposal, to only those who say they are just taking it to get off of it.

Congressman SCHEUER. Well, maybe that should be our program.

Mayor KOCH. No, absolutely——

Congressman SCHEUER. That certainly would be one possibility.

Mayor KOCH. Then all they would do is to sign up and say "I want to get off of it," and stay on it for the rest of their lives. The fact is people's—and you will get more experts on this, craving for cocaine is so extraordinary that most people do not believe that many people in treatment could, in fact, be capable of getting off it. Some will.

With heroin, you go to methadone. With cocaine, as you know, you have got to be drug-free. And it is such a compelling craving that it is very hard to have people successfully go through very long programs.

All of the cocaine programs that have any success are very long programs, a year or more, which is different than methadone. I see a total difference.

Chairman RANGEL. How many members would want to inquire of the Mayor before he leaves, so I can have some idea.

Congressman SCHEUER. Let me have one question.

Chairman RANGEL. Go ahead.

Congressman SCHEUER. Mr. Mayor, if it is that impossible to rid a cocaine addict—to help him get rid of his addiction——

Mayor KOCH. Very difficult.

Congressman SCHEUER [continuing]. And if the law enforcement system is as totally incapable of interdicting the flow of cocaine from——

Mayor KOCH. We haven't really done it.

Congressman SCHEUER. Well, we have done it. Hey.

Mayor KOCH. No, we haven't.

Congressman SCHEUER. Do you have a law enforcement official who will tell you that with the addition of "X" billions of dollars a year, we could measurably reduce the drugs of substance into our neighborhoods?

Mayor KOCH. Let me just make a very brief statement on that. I do not believe that we have committed the resources, even this Congress—not the people over here, because I know you are dedicated to this, but the last drug bill is a fraud. You say there is $230 million for law enforcement. I am told the maximum that is available is $70 million. And if I am wrong, please tell me. That is a fraud on the public. $230 million is a fraud on the public nationwide.

Do you know that in the City of New York, we are spending about $450 million? And you say—well, that establishes that it isn't working. I want to tell you we would be more inundated if we weren't putting people in jail.

Now, I believe, for example, the Federal Government has a major responsibility, which it has just failed to do. You can't grow cocaine and heroin in Central Park. Everybody knows that. It has got to come over the borders.

And to me, what was shocking—and if you will permit me to say it as I have served with you. Many members here, particularly the Chairman and I, worked so hard and Congressman Gilman as well worked so hard to get military interdiction into the House Omnibus Drug Bill. We got it in two years ago; the Senate wouldn't take it.

This year we got it into both Houses. It was a miracle, military interdiction. And somehow or other in conference—and you and I know that if a measure gets in, even though different, but in both Houses, when you get to conference, something comes out that resembles one or both or a compromise—they took it all out.

I don't know how they did that. I'm sure it was legal. But the fact is it was unusual. You know that and I know that. This country, the people are out there committed to doing something about drugs. Regrettably, the Federal Government is not committed.

Now, in Japan, they eliminated the drug problem. You talked about Singapore, Jim, as though it were a terrible society. It happens to be one of the most advanced democratic societies in all of Asia. They have democratic elections.

And if they didn't think that whipping, "lashing," as you said it, was appropriate in that society, they would vote it out. It is not the only society in——

Chairman RANGEL. It's strange that people would talk about lashing, and then they support the death penalty here, you know.

Mayor KOCH. No, no, no. Hold on. Do you know, Jim, until 1948 this country permitted whipping? It was eliminated in 1948 in a case involving Delaware, and the Supreme Court, it is my recollection, went on to say, "But you can still use it with students, but not with criminals."

Congressman SCHEUER. Well, Mr. Mayor, you heard Congressman Guarini say, and I don't think he was entirely kidding, if it is a question of the death penalty or if it is a question of the lash, which seems to have a tremendously concentrating effect——

Mayor KOCH. Well, we ought not——

Congressman SCHEUER [continuing]. On the minds of young people in Singapore——

Mayor KOCH. We ought not to kid ourselves. The death penalty——

Congressman SCHEUER [continuing]. He would prefer to have the lash.

Mayor KOCH. The death penalty will not eliminate drugs. But I believe it should be available. And if I had been here, I would have voted for it. I have been supportive of it in appropriate cases.

Congressman GUARINI. Would you yield, Mayor?

Mayor KOCH. What?

Congressman GUARINI. I agree with you. I voted for the death penalty.

Mayor KOCH. Sure.

Congressman GUARINI. I was misquoted by my colleague, but he paraphrased it. The fact is that I agree with your status. I do believe that——

Mayor KOCH. These are the answers: interdict as much of the drugs so they don't come into the country; when they come here do as much arrest as you can; have an educational program that is meaningful.

We don't even have a national educational program. I wrote to the Secretary of Education. I said, "I looked at our films that we use in our school system, and they stink. Why don't you get, 'Against Drugs'? Why don't you get a film nationally with all of the resources the Federal Government has that"——

Congressman COUGHLIN. Mr. Mayor, anti-drug films of this kind will be distributed this fall.

Mayor KOCH. What's that?

Congressman COUGHLIN. You will have anti-drug films this fall.

Mayor KOCH. Well, good.

Congressman COUGHLIN. They are coming out right now.

Mayor KOCH. I hope so. Now, on the first day of school, I went into an elementary school and I spoke, so help me, God, first grade, second grade, third grade. These are kids that are six, seven years old.

And I always like to treat kids as adults talking their language, because you get a lot more out of them when you do that. So I said, "Listen, kids, how many of you know what crack is?"

First grade, so help me, God. And they looked at me in amazement, like I was a loony. "Mayor, crack is drugs." And then I said to those kids, "How many of you know anyone who takes drugs?" Fully 25 percent of the kids, first grade, raised their hands.

And I said, "What would you do if someone offered you drugs?" And the kids were wonderful. They said, "Oh, I would tell the teacher"; "I would tell my Mommy." Good. There is some, at least, education out there.

But there are no real—you know, most of us were in the Army. Do you remember those sex films?

Chairman RANGEL. Terrible, terrible.

Mayor KOCH. Charlie?

Chairman RANGEL. They're terrible.

Mayor KOCH. Scared the hell out of you; right?

Chairman RANGEL. Terrible, terrible.

Mayor KOCH. Okay. Why can't we have films that scare the hell out of kids on drugs? Right?

Chairman Rangel. Makes sense.

Mayor Koch. Okay.

Chairman Rangel. Let me thank you——

Mayor Koch. Thank you.

Chairman Rangel [continuing]. For taking the time out. And I yield to the gentleman from Maryland, Mr. McMillen.

Congressman McMillen. Thank you very much, Mr. Chairman, for this opportunity to introduce my good friend, Dennis Callahan, who is Mayor of the largest city in my district and the most beautiful state capital in the country.

And before doing so, I would like to make just a couple of brief comments on the issue in general. From my own experiences in the N.B.A. and the Olympics, I have literally seen drug use firsthand. I have seen it destroy careers of famous athletes.

I am pleased to see that the N.B.A. has taken some positive steps in this regard towards a comprehensive approach to drug use in its ranks, not only penalizing those who use it, particularly second-time users, but also providing help for those who are caught up in the vicious cycle.

Like my colleague from Maryland, Ben Cardin, I have done a lot of town meetings on this issue. And truly the consensus that I have received is that we need a comprehensive approach to this problem, education, rehabilitation, enforcement, interdiction, before we even consider decriminalization or legalization.

I can understand the Mayor of Baltimore's call for legalization, given the frustration in dealing with this problem. Until we take a comprehensive approach backed by sufficient resources and strong leadership, it is premature to say that we failed in the drug war.

The Mayor of Annapolis, Dennis Callahan, has been one of the leaders in the fight against drugs. In his city, he has established a very successful zero-tolerance policy. His vigilant crackdown on drug abuse has led to many arrests and has involved the entire community in meeting this grave threat. I think you will find his testimony compelling and interesting.

Mayor Callahan, you have an outstanding example of what leadership in this area can accomplish.

Mr. Chairman, I congratulate you and the members of the Select Committee for conducting this hearing. Legalization is a most controversial issue. I know that you have personally taken a strong and outspoken stand against the legalization of drugs.

I want you to know that I admire your willingness to examine this issue thoroughly, and I want to thank you for allowing me to introduce my good Mayor. Thank you.

Mayor Callahan. Thank you, Tom.

Chairman Rangel. Mayor, your entire statement will be entered into the record. We do have a restriction, even though you wouldn't know it from the last witness. But we do have a five-minute restriction and we hope that you will be able to stay within it.

Thank you very much.

TESTIMONY OF THE HONORABLE DENNIS CALLAHAN, MAYOR, ANNAPOLIS, MD

Mayor CALLAHAN. Well, Mr. Chairman, I do recognize that restriction, and members of the Committee and I would like to thank you for allowing me to speak after Mayor Koch. I forgot most of what I was going to say while I was sitting here.

I agree with what he said. You know, it is interesting. I am another mayor from Maryland, and it is coincidental that Kurt Schmoke and I went to the same high school. We were born and raised in the same city. We play each year an alumni football game. We are on the same team. But we are not on the same team on this issue, and I say, Kurt, you are wrong.

Annapolis is the home of the Naval Academy, the capital of the State of Maryland, and last month we were featured in a 28-page article in the "National Geographic," and they referred to us as the "camelot on the bay entering our second golden age."

Well, gentlemen, I am here to tell you there is trouble in Camelot. I am here to tell you that regardless of the size of your city or your community, regardless of your financial situation, you have a serious drug problem. I should say we have a serious drug problem.

The legalization argument seems to rest on the concept that drug laws and not drug abuse itself is where the problem is. And to me, that absolutely boggles the mind.

The crime of drugs is not a crime against property. It is a crime against our youth. It is a crime against our future. It is a crime against our very moral fabric. How can you possibly equate the cost of additional police officers, police overtime, Coast Guard equipment, Coast Guard personnel to the life of a child?

I totally reject the argument when we start talking about dollars and cents, but I will pursue that because I know that has been an issue before this particular group.

The Triangle Research Institute, which is outside of Duke University in North Carolina, has said that the drug problem costs this nation $60 billion. I won't bore you with the specifics. There was a lot less spent for drug enforcement than there was on the problems caused by drugs.

But I would like to make this point, and, of course, I am now talking about alcohol, and alcohol is legal in our country, that same Institute said that alcohol abuse, which is legal, cost this country $117 billion.

Only $2.5 billion was law enforcement. The other approximately $115 billion was because of accidents caused by people that were abusing, hospitalization, cirrhosis of the liver, lost productivity.

And I think that makes the strongest argument. The most compelling argument we have today against the legalization of drugs is the problem we have with alcohol.

And I'm not sitting here as a teetotaler. I just think we are making a big mistake for the elected leadership, regardless of whether it's a municipality or a national level, to somehow cloak drugs with a mantle of respectability by saying that this is somehow okay.

And if, in fact, in your infinite wisdom,—I'm talking about the Congress; not to this group—we were to determine that we are going to legalize drugs, what drugs would you legalize? Would marijuana be one? The great myth, marijuana. I consider it a gateway drug, by the way.

We had a debate on W.R.C., which is a local radio station not too long ago, local in D.C. And I was debating the fellow that was the head of N.O.R.M.L. He was the President. It is an organization that has been trying to legalize marijuana for many years.

And he said, "You know, if you overdose on cocaine, Mr. Mayor, you die; if you overdose on heroin, you die; but if you overdose on marijuana, you fall asleep." And I said, "Yes. At the wheel of a Conrail and kill 16 people."

Now I would ask you, do you really think that the children or the parents or the husbands or the wives of the victims on Conrail really care where that addict got his drug? Do you think it makes a difference whether he bought it on the street or had it stamped "U.S.D.A.-approved"? I don't. I go back again and say this is an attack against our very moral fabric.

Now, I saw some of the previous testimony by Mayor Schmoke, and I heard some of the questions. And the last five minutes of the first segment seemed to be zeroing in on, "Well, how do we know that legalization will cause more people to be using drugs?"

Gentlemen, I have something from P.R.I.D.E., the National Parents' Resource Institute from Atlanta, Georgia, and I have been told I am the first one to make this announcement at a national level. This was Federal Expressed to me yesterday when they heard I was giving testimony.

The first part you may know. I didn't know it. It shocked me. The State of Alaska—I'm sorry we don't have a Representative here. I would like to ask him a few questions about it. The State of Alaska allows you to legally grow your own marijuana if you consume it on the premise, but only if you are an adult. Now that apparently has been known to some people. It shocked me.

But here is what hasn't been known: 250,000 high school seniors responded to a survey from this group of P.R.I.D.E., and on a national level, 1 out of 5 high school students admitted to smoking marijuana. In Alaska, it is 1 out of 2. They exceed all other states by over 100 percent.

And I submit to you this is not coincidental. I submit to you because the smoking of marijuana has a mantle of approval by the local government, and I submit to you that people in high school were doing what grown-ups and their parents do or what is perceived to be the "neat" thing to do. And I think this is a mistake.

You saw my testimony. I won't get into the life threats. I know we have other things to do here. Let me close with one remark that I mean from the bottom of my heart, because I believe we have made a turnaround in the City of Annapolis.

We have a long way to go, and we have made the turnaround by informing our public, by educating our public, and, yes, by being very hard when it comes to law enforcement.

Fifty years ago there was a gentleman for whom I have the most respect. I think he was, in fact, a world hero. I think he is probably now a prophet. And when his country was surrounded by what many considered to be an overwhelming enemy, and he had no allies, by the way, Sir Winston Churchill said this, "Victory at all costs. Victory in spite of all terror. Victory no matter how long or hard the road may be, because without victory, there is no survival."

I believe that. And I thank you for allowing me to share my views with you.

[Statement of Mayor Callahan appears on p. 253.]

Chairman RANGEL. Thank you, Mr. Mayor.

Jack Lawn is the Administrator of the Drug Enforcement Administration, a group of dedicated people that has been the lead agency in our so-called "war against drugs" and not only in the United States, but abroad.

And it is interesting that all of the witnesses would believe that we have put all of our resources in law enforcement.

And since you have the privilege of heading up that international force of 2,800 agents here and abroad, I guess you have been looking for the total commitment to law enforcement that people have been talking about.

But we want to thank you for your valiant efforts, and we are anxious to get your views. And we thank you for your patience with the Committee.

Jack Lawn?

TESTIMONY OF THE HONORABLE JOHN LAWN, ADMINISTRATOR, DRUG ENFORCEMENT ADMINISTRATION

Mr. LAWN. Thank you very much, Mr. Chairman, members of the Committee.

Let me say from the start that I am unalterably opposed to the legalization, any legalization of any illicit drug for any general use. Drugs are not bad because they are illegal. They are illegal because they are bad.

I welcome the discussion on legalization because, armed with the facts and historical data developed through a forum like this, we can put the legalization issue to rest once and for all.

Americans, unfortunately, are used to quick fixes for our problems. But those of us who are concerned with both the supply and demand reduction have long recognized that there are no quick solutions.

The drug problem has been a long time developing in our country and it will take a long time to correct. We must allow our relatively recent drug abuse prevention and education programs to do their job.

The major flaw in legalization theory is that it misses the point. Drugs themselves, not drug laws, as you have heard so many times, cause the most damage to society.

Again, as you have heard so many times, we really need to learn from what should have been a lesson with alcohol. Dr. Mark Kleiman, a criminal justice expert who teaches at Harvard University, has said, "I think that our experience with alcohol is the strongest argument against legalization of illicit drugs."

Prohibition in the '20s dramatically decreased average consumption levels of alcohol. Now average consumption is back to pre-prohibition levels. This historic perspective clearly illustrates a very important point, greater availability results in greater use and greater abuse.

Today's alcohol abuse statistics are frightening. The National Council on Alcoholism says that 1 out of every 3 American adults claim alcohol abuse has brought trouble to their families. In 1985, nearly 100,000 10 and 11 year olds reported getting drunk at least once a week. We can attribute over 100,000 deaths a year in the United States to alcoholism. Over 23,000 people are killed on the highways each year. Cirrhosis of the liver is the sixth leading cause of death in our society.

We must learn from our experience with alcohol. The past is, indeed, a great teacher. We must learn from history, or we are doomed to repeat it. History has shown us time and again that when addictive drugs are socially accepted and easily available, their use is associated with a high incidence of individual and social damage. With history as our guide, we must consider what we will do with our future.

I would now like to touch on a few of the points I made in my statement for the record. I believe that legalization would send the wrong message to the rest of the world. The United States would violate international treaties that we have signed if we were to legalize illicit drugs.

The United States is a signatory to the single convention on narcotics drugs of 1961 and the convention of psychotropic drugs in 1971. These treaties obligate us to establish and maintain effective controls on substances controlled by those treaties.

United States violations of these treaties would destroy our credibility with drug source and drug transit countries who are now working with us in the global war on drugs.

It is also my opinion that legalization would send the wrong message to our nation's youth. At a time when we have urged our young people to "Just say 'No' to drugs," legalization would suggest that they only have to say "No" until they are a little older.

It stands to reason that children would be confused about real consequences of drug abuse when drugs are forbidden to them but are readily available to others in that society.

As a father of four children, I am deeply concerned about the effect that legalization would have on all of our youth. As the nation's chief drug law enforcement officer, I am deeply concerned about the effect that legalization would have on crime in our country.

The popular misconception is that drug users commit crimes solely to support their drug habits. This misconception leads to the false conclusion that lowering the cost of drugs would reduce the level of crime. In reality, cheaper, legal drugs would probably increase the level of violence and of property crime.

Never before has cocaine been available in this country at such low costs and at such high potency levels as we are seeing today. Cocaine and its derivative, crack, have contributed significantly to the recent increase in violent crime in all of our major cities, including our Nation's Capital.

Even legalization proponents concede that other crimes, such as child abuse and assaults on children, that are committed because people are under the influence of drugs would not decrease.

It stands to reason that the increased drug use caused by legalization would result in a surge of incidence of random violence and higher crime rates.

There is no real human cry from the American people for legalization or decriminalization of illicit substances. Recent Gallup polls and A.B.C. polls have shown widespread opposition to legalization. Legalization is offered as a simplistic answer to an extremely complex issue. The real answer to the drug problem in America today is not legalization.

Our focus must be to reduce demand as well as to reduce the supply. Instead of giving to faulty approaches like legalization, we need to work together to do everything possible to win our nation's war against drugs.

Mr. Chairman, that concludes my brief remarks.

Chairman RANGEL. Thank you.

[Statement of Mr. Lawn appears on p. 260.]

Chairman RANGEL. Just for the record, your agency is the lead law enforcement agency as it relates to drug violations; is that correct?

Mr. LAWN. Yes, sir.

Chairman RANGEL. And in this war against drugs, what is the total man and woman power, total number of people, that you have as far as agents are concerned?

Mr. LAWN. In the Drug Enforcement Administration, we have a total of 6,000 personnel.

Chairman RANGEL. And as far as the agents are concerned, how many agents do you have?

Mr. LAWN. 2,800 personnel, as you had mentioned earlier, serving around the world.

Chairman RANGEL. In this war against drugs that everyone is talking about, you're saying that those that are trained to enforce the federal narcotics laws here and around the world number less than 3,000?

Mr. LAWN. Yes, sir, but we are one of an army of components involved in that war.

Chairman RANGEL. And you are the lead point of that army?

Mr. LAWN. Yes, sir.

Chairman RANGEL. Okay. Let's hear from Arthur C. "Cappy" Eads, the Chairman of the Board of the National District Attorneys Association.

STATEMENT OF ARTHUR C. "CAPPY" EADS, CHAIRMAN OF THE BOARD, NATIONAL DISTRICT ATTORNEYS ASSOCIATION

Mr. EADS. Mr. Chairman and members of the Committee, I would like to, first of all, thank you for affording the prosecutors in this country the opportunity to not only share their opinion, but their deep concern and their opposition towards the whole subject of the legalization of narcotics in the United States. We not only appreciate the opportunity, but hope that our remarks will be included in the record, Mr. Chairman.

Chairman RANGEL. Without objection, Mr. Eads.

Mr. EADS. The National District Attorneys Association and its over 7,000 members, the prosecutors that stretch from New York to

San Diego, not only stand unequivocally opposed to the legalization of narcotics, but, in expressing their concern, feel that the whole issue of legalization of narcotics ignores the fundamental reason why drugs were made illegal in the first place.

But most simply, drugs are illegal because they are bad. They are bad for our society. They are bad for the user. They are bad for those around the users and for our communities.

Children whose parents abuse, neglect, and even murder them under the influence of drugs are suffering. Those statistics are up in drug-related cases from New York City to Washington State.

As a member of the President's Partnership on Child Abuse, we held hearings across this country, in New York, Chicago, Austin, Orlando, Seattle, and Denver. And of all the over 200 witnesses that we heard on that Commission, invariably, in those cases that were related to child abuse, to child molestation, to child runaway, to child throwaway was the deep-rooted problem of substance abuse, and not the issue of whether it was legally or illegally consumed.

The benefits claimed for legalization or decriminalization are overstated and, in large measure, unachievable. As the price of cocaine goes down, the crime rate rises. The cost of narcotics in this country in its relationship to the crime rate, although significant, will not be one which will go away.

Claims that funding for drug-related law enforcement could be transferred to education and prevention wrongly assume that these two areas are distinct and in competition.

Prosecutors strongly support treatment programs. They are an essential ingredient in drug offender sentencing. Legal sanctions against drug use are a critical component of effective prevention and treatment programs.

There is overwhelming agreement among drug offender treatment specialists that criminal sanctions, when used effectively, can assist in keeping the offender drug-free and in treatment.

The D.W.I. law is an example of those who are arrested and convicted of driving while intoxicated and being placed in treatment programs, otherwise unavailable or undetected.

The law's equivalent of prevention is deterrence. Legalization would remove this deterrent effect. And legalization of drugs would have a disproportionately negative impact on poor communities, where many young and underprivileged have turned to drugs in this country.

There are those who have said that the war on drugs has failed. It is in trouble not because of lack of effort of those involved in the law enforcement community.

But a full-scale war on drugs, combining law enforcement, prevention, and treatment efforts has yet to be tested. There has yet to be the commitment in this country that, although politics certainly is the law of compromise, that this is not an issue upon which we will compromise. We will not deal. We will not negotiate. We will draw the line in this country.

And the public in this country is enraged and there is a gulf of sentiment, gentlemen, in the courtrooms across this country that are so overwhelmingly opposed to not only the use of drugs, but to the legalization of drugs that is overwhelming. Follow us into the courtrooms to see and listen to the juries speak as to the public's attitude regarding legalization.

No drug dealer or user should escape punishment because local law enforcement lacks training, resources, or expertise. No offender should be free in a community if he continues to use drugs, whether convicted of a drug offense or any other offense.

Mr. Chairman, I ask you, how do I as a prosecutor explain to parents that drugs that killed or destroyed their child were not only legal, but sanctioned by Congress?

How do I as a prosecutor explain to the victims of violent crimes that the drugs that propelled their crazed assailants were legalized in this country? How do we tell the family members and loved ones of victims that were killed in violent crimes that the money stolen was to support an addict's legal habit, not an illegal habit? And what's the difference?

And how do we tell those who are users and abusers that there is no help available from the prosecutorial to the criminal justice system?

District attorneys know that this war is being fought on the streets of their communities, and they are scarred veterans of this war. But they know that without the support of the Federal Government, that these communities do not have all the necessary resources to win, that a drug bill with no concomitant dedication of resources is a headless horseman, that we must have the financial commitment from Congress.

I know that in serving as the vice chairman of the Texas Drug Task Force and in the hearings that we heard across the State of Texas, that it was the same plea, and it was the same cry for support for those integrated drug task forces to interdict and to fight the importation of drugs across our international border that stretches between the State of Texas and the country of Mexico.

Again, we thank you for the opportunity to testify and place ourselves before you to answer any questions that we may. Thank you.

Chairman RANGEL. Thank you, Mr. Chairman.

[Statement of Mr. Eads appears on p. 272.]

Chairman RANGEL. Sterling Johnson, a friend of mine and old friend of this Committee, a super prosecutor, a special person, and the Special Narcotics Prosecutor for the City of New York, we once again are honored to get your views.

Mr. Johnson?

STATEMENT OF STERLING JOHNSON, SPECIAL NARCOTICS PROSECUTOR, CITY OF NEW YORK

Mr. JOHNSON. Mr. Chairman and members of the Committee, it is my privilege to appear before you again and express my views on this real burning issue of the legalization of drugs.

I listened to Mayor Koch and I was amazed that I agreed with everything that he said except that point about the needles. And he was eloquent in his presentation. We must not, we cannot have legalized or decriminalized drugs in our communities.

First of all, we cannot do it without violating treaties, as my friend Jack Lawn said. It is just impossible to do. It is morally, ethically, and wrong religiously.

I listened to my friend Kurt Schmoke, and I have known him for a number of years, and some of the things that he said were utterances of frustration. We agree that we have a problem, that something must and should be done.

We agree that for the past 15 or 16 years there has been no strategy coming out of Washington, DC. I was amazed at the last Congressional hearing that I appeared before with you and Congressman Garcia that in the past 8 years, there has not been one piece of legislation, drug legislation, coming from the Executive Branch of this government, that the only legislation that did come from Washington during that period of time has been from the Congress.

Both the Democrats and the Republicans in the legislature put forth legislation such as the Omnibus Drug Bill of 1986 and the current one of 1988.

I heard my friend Kurt Schmoke use such terms as he would like to legalize drugs so they can "maintain" a heroin addict. That is an inconsistent term. You do not maintain a heroin addict.

If you have an addict who is using $100 a day and you give him $100 a day, then his habit becomes $200 a day. And it will go on and on and on. If you give him something less than the $100 a day, then there is going to be a need for the black market that we have right now.

Mayor Koch was correct when he pointed out, although Mr. Schmoke would legalize cocaine and not legalize crack, you would still have a cocaine black market out there because in order to make crack, you need cocaine. And people would buy the cocaine and make the crack, and you would have the same problem you are having today.

Another question I would ask of Mr. Schmoke, when he was talking about legalizing heroin or cocaine, would you give these drugs to a pilot who is going to fly the plane that he is taking off on to visit a sister city?

Would you give this drug to a doctor who is going to perform an operation on someone that he knows? What age limit would you cut it off at, if you would cut it off? Why would you confine it to certain drugs because if it is just going to be heroin and cocaine, there are other drugs out there, if you are going to be consistent?

If you think for one minute that giving free drugs or legalizing drugs or decriminalizing drugs is going to stop crime, you are sadly mistaken. And we have the empirical evidence of the experiment in England to demonstrate that people who are receiving free heroin went out and committed crimes the way they committed crimes before they received the free heroin.

And, finally, the issue of free needles, I am opposed to. And the Mayor intimated that I express my opinion as to what I thought of free needles. First of all, it is sending out an erroneous signal. We are tough on drugs, but we are giving free needles.

The purpose of free needles is to stop the flow of the intravenous virus. But we really are not going to stop that flow or we really don't know if we are going to stop that flow. You are giving a needle to an unsupervised, unsanitary, unreliable human being called an "addict."

These individuals don't wash their teeth or any other part of their body. They are going to take their needle. They are going to go into some shooting gallery. And you don't know what they are going to do with the needle. And then they are going to come back and say, "Give me another needle."

Or do we really know if the addict is going to shoot up five, six times a day. And they do this. Will they get five and six needles at one time?

I must say that I agree with all of the experts, including Mayor Koch, except on the issue of free needles.

Thank you again.

Chairman RANGEL. Thank you, Mr. Johnson.

Chairman RANGEL. Our last witness on this panel is Jerald Vaughn, the Executive Director of the International Association of Chiefs of Police.

And I advise my colleagues that the vote that is on is the motion to accept Senate amendments to the Foreign Appropriations Conference Report. After we take the testimony of Mr. Vaughn, if the panel could allow us to go vote, we will be back in 10 minutes.

Mr. Vaughn?

TESTIMONY OF JERALD VAUGHN, EXECUTIVE DIRECTOR, INTERNATIONAL ASSOCIATION OF CHIEFS OF POLICE

Mr. VAUGHN. Thank you very much, Mr. Chairman.

The International Association of Chiefs of Police consists of over 15,000 top law enforcement executives from the United States and 68 other countries. I can say without any hesitation that the law enforcement executives in the United States and other nations are unequivocally opposed to the legalization of drugs and, in fact, are quite concerned even about the ongoing debate on this topic. The debate appears to provide legitimacy to a cause that ultimately is detrimental to the health, welfare, and safety of all American citizens.

Society simply should not compromise those reasonable values held by decent people in pursuit of simplistic solutions to a very complex drug problem. To suggest that legalizing drugs will cure our crime problem is naive and unrealistic. Drugs are diabolical and destructive, not only to the human system, but to a democratic way of life.

Much has been said about the failure of law enforcement to curtail the drug problem. We do not believe there has been such a failure. From the law enforcement perspective a comprehensive drug strategy involving all parts of the criminal justice system has not been in operation.

If the issue is overcrowded court dockets, overcrowded prisons and jails, law enforcement has been successful. We have not, however, had the level of support and commitment from the other elements of our criminal justice system to handle the load that has been created up front. The result is that dangerous, violent repeat offenders, quite often drug traffickers, are back out on the streets again.

Proponents of legalization say that we are draining off scarce resources and throwing it away on ineffective law enforcement measures. That is an absurd argument, particularly in view of the fact that as a Nation only three percent of total government spending at the Federal, State, and local levels is allocated to our entire civil and criminal justice system, only 1.4 percent of total government spending goes for the provision of law enforcement services, and only six-tenths of one percent of the Federal budget goes for law enforcement services.

We are trying to fight a battle against crime and a battle against drugs with an army that is minuscule, less than 500,000 police officers to protect the lives and property of 245 million citizens; our lead drug law enforcement agency with less than 3,000.

To say that we could free up those resources for other things, there are few resources there to start with.

Pro-legalizers hypothesize that legalization will reduce crime and violence. Are they predicting that addicted users will become employed or remain employed? That is ludicrous. Addicts will still have to generate a source of ready cash in order to purchase drugs.

Do proponents of legalization honestly believe that those who now accrue large sums of money through drug-dealing will suddenly acquire legitimate job skills and become law-abiding citizens, family-oriented citizens?

Will young drug traffickers voluntarily take their hand out of the cookie jar of plenty and voluntarily return to either unemployment or a minimum wage scale job? Should we believe that legalization will miraculously change all of this?

Crime and the relationship between crime, violence, and drugs is there, but to say legalization is the only alternative is wrong. The fact is that if all other efforts have failed, there may be other, better alternatives.

In cooperation with the Justice Department, Bureau of Justice Assistance, and the Drug Enforcement Administration, the International Association of Chiefs of Police conducted a series of 5 drug strategy sessions throughout the United States last year. We called together Federal, State, and local law enforcement people, prosecutors, corrections people, and educators.

What we found is that, in fact, you can reduce crime by reducing drug abuse. We have developed a comprehensive manual that outlines cooperative, community-wide strategies to deal with the drug problem.

We are very concerned about the argument used by proponents of legalization that states that legal restrictions on drug use and availability is an infringement on civil and individual rights.

I would assure this Committee that as a Nation we have seen fit to regulate the sale and distribution of harmful substances since the 1700s and no one has yet decried this is a rights infringement.

We protect our citizens from diseased meats, poultry, and seafood, false branding and marking of food substances, poorly prepared serums and vaccines, food additives, food coloring, milk, alcoholic beverages, and dangerous nonprescription drugs.

We regulate these consumer products because we cannot depend upon producers and manufacturers to place the consumer before profit.

Chairman RANGEL. You will have an opportunity to conclude your statement, but our time is running out, and so we are going to recess for 10 minutes and return.

[Recess.]

Chairman RANGEL. When the Committee recessed, Mr. Vaughn was concluding his testimony.

Mr. Vaughn?

Mr. VAUGHN. Thank you very much, Mr. Chairman.

I would like to conclude my testimony with two observations. I would like to share with you something that Prime Minister Margaret Thatcher said that I think reflects the prevailing attitude of police in this country with respect to the whole issue of legalization.

She recently said in a public announcement or a warning to drug pushers in Great Britain, "We are after you. The pursuit will be relentless. We shall make your life not worth living."

Isn't that the side that we should be on? As we look at our frustrations in this war on drugs, at least as we have experienced it to date in this country, we are frustrated. We wish our successes were greater.

But legalization, at least in our judgment, is not even realistic as an option. It could only be described as a last resort, when all else has failed. And all else has not failed. Legitimate and viable courses of action still exist.

It is a little bit like a professional mountain climber who encounters a sheer rock face. He doesn't pale and seek an easier route; he draws upon his best and strongest skills and determination.

And that is where we as a Nation need to go. There is more we can do with respect to dealing with our drug problem in the United States without entertaining such fatalistic notions as legalization of drugs.

Thank you.

[Statement of Mr. Vaughn appears on p. 282.]

Chairman RANGEL. Thank you, Mr. Vaughn. You indicated in your testimony that you thought that these hearings would give some type of legitimacy to the question of legalization. I think we are serving our purpose.

There was a lot of television talk and campus talk about legalization. If you listen closely to the testimony today, you will see that people just want to discuss it. They want to debate it. They don't want to participate in the debate; they want someone else to debate it.

They now want a commission. They want to take another look at the alternatives. With whom, we don't know, but I understand that it takes a lot of courage even to say that. But in any event, I don't think we have any serious threat of anything being legitimized.

I would like to ask Mr. Lawn, since you do represent the point in our federal government in the war against drugs, you have no problem with that description, do you?

Mr. LAWN. Not until I hear the rest of it, Mr. Chairman.

Chairman RANGEL. And since you know my strong support for the dedication of the men and women in the Drug Enforcement Administration; and since you have testified over and over that law enforcement is a part of the answer, but is not the total answer to this great problem that our nation and, indeed, the free world faces; and since so many people are saying that we have lost the war or we are losing the war or what we are doing is not working; and since I come from the school of thought that says we are not doing that much, maybe we can go down and allow me to ask you some questions.

As it relates to rehabilitation, do you know of any federal rehabilitation program that we have in our arsenal in this so-called "war against drugs"?

Mr. LAWN. That certainly is outside the purview of my level of expertise, but, indeed, the answer is no, Mr. Chairman.

Chairman RANGEL. Okay. Now, I assume education is a big part in this so-called "war," and we know about "Zero Tolerance" and "Just Say 'No' " and abuser accountability, but as a soldier in this war and a part of the federal effort, do you know of any educational program that is working along with you in this war against drugs?

Mr. LAWN. Yes, sir, I do. There are any number of programs, our own program in the Drug Enforcement Administration, the program where we work with the high school coaches, I believe, is an effective program.

Chairman RANGEL. Well, when I say "federal," I mean a national program. If you have 2,800 agents here and abroad, you are telling me that some of those agents are involved in educational programs?

Mr. LAWN. Yes, sir, in educational programs with the 15,000 high school coaches around the country. They are part of the army.

Chairman RANGEL. That means that they are not involved in law enforcement?

Mr. LAWN. Yes, sir, they are. This is what we call an "additional" duty.

Chairman RANGEL. So the educational program that we can tell those people involved in the war against drugs about would be the educational program that is supported by the law enforcement officers, that do federal education as a part of their regular duty?

Mr. LAWN. No, sir. Bill Bennett at the——

Chairman RANGEL. Let's talk about Bill Bennett, the Secretary of Education. Tell me about the federal education programs that came out of the Department of Education.

Mr. LAWN. Mr. Bennett and the Department of Education sponsored a booklet, which was widely distributed around the country, and it is, again, one of the things in the education area which I think will be very helpful.

Chairman RANGEL. Terrific. So the federal education program, as you know it, as one of the generals in the lead enforcement effort, is a red booklet which Secretary of Education Bennett had distributed to—to superintendents of schools or to principals, or what?

Mr. LAWN. Principals, teachers.

Chairman RANGEL. But that is our federal effort. Okay.

Let's talk about interdiction. Senator Quayle was not familiar with it, but I am. Could you share with the Committee the responsibilities of the Vice President of the United States as it relates to interdiction?

Mr. LAWN. Yes, sir. The Vice President in 1981 organized the South Florida Task Force, and it was an interdiction task force, a multiagency task force to look at the interdiction of drugs coming into Florida. That effort has continued.

Since that time, the Vice President has put together the National Narcotics Border Interdiction System. It is a system with which we work in sharing intelligence among law enforcement components. And the Vice President has continued to be very active in this area.

It was through the Office of the Vice President that we were able to initiate Operation Blast Furnace in Bolivia when the Bolivian Government requested assistance two years ago. It was through the personal intervention of the Vice President that that operation was initiated and was, in fact, effective.

Chairman RANGEL. And did he work very closely with the Secretary of Defense in shoring up our interdiction strengths on our borders and air? Because I have not heard, and you can state for the record, any of our Secretaries of Defense ever being involved in this war against drugs. Most of them say that it is not a military matter.

Mr. LAWN. No, sir. In point of fact, the A.W.A.C.'s aircraft that last year, I think, flew in excess of 5,000 hours in air drug efforts. We last year, the law enforcement community, made about 5,000 requests of the military for logistical support. And I believe that about 94 percent of those requests were honored.

Additionally, the military has provided specific training for our personnel going to South America on an initiative about which you are aware. The military has been involved in logistical support and in training and in other areas.

Chairman RANGEL. So you would say that our Secretary of Defense is a part of this war and has proclaimed his strong defense and support for your efforts?

Mr. LAWN. Yes, sir. He has been supportive of our efforts when we have asked for that support.

Chairman RANGEL. And let's go to the Secretary of State as it relates to foreign policy in countries that grow drugs. Do you recall any statements made publicly, at least for the general public, not in-house statements, that were attributed to the Secretary of State, as it relates to foreign sources of opium and cocaine and marijuana?

Mr. LAWN. Yes, sir. Most recently, I recall that the Secretary of State was in La Paz, Bolivia where an attempt was made on his life. He was there on a drug mission.

I also recall, I can't recall the date, where the Secretary gave a speech to a group in Florida, specifically addressing the drug issue.

Chairman RANGEL. So you are saying that in your experience, you remember two speeches given by the Secretary of State, one in Bolivia and one in Florida, on drugs?

Mr. LAWN. I am saying specifically in the near term, I remember his visits——

Chairman RANGEL. Yes, specifically. Because I see him almost every other Sunday on television, and I haven't been with him in Bolivia, but you say I missed the one in Florida?

Mr. LAWN. Perhaps you did, yes, sir.

Chairman RANGEL. You don't know of any others, though?

Mr. LAWN. They don't immediately come to mind, no, sir.

Chairman RANGEL. Okay. Well, my point is that I think you would agree that a lot has to be done in this so-called "war against drugs," and it is not all law enforcement. And I think before we concern ourselves about giving up on this, that a lot has to be done by the Congress and by the administration.

I yield to the gentleman from New York, Mr. Scheuer.

Congressman **SCHEUER**. Thank you, Mr. Chairman.

It has been a very interesting panel, and I want to thank you all for your forthrightness. Let me ask a question of any of the prosecutors who would care to answer. Well, I would include Jack Lawn.

We are now interdicting somewhere in the process before the drugs come to the neighborhoods, as I understand it, maybe 10 or 15 percent of the drugs that are shoved into the pipeline.

Would that be an approximate figure?

Mr. **JOHNSON**. I think it is kind of high, but I will accept that.

Congressman **SCHEUER**. Sterling, what would you say it is? 10 percent? 5 to 10 percent?

Mr. **JOHNSON**. 5 to 10 percent.

Congressman **SCHEUER**. 5 to 10 percent. Now, I have been on this Committee under Charlie Rangel's leadership for close to 15 years, and it has been that level all the time. Sometimes we say 5 to 10 percent; sometimes we say 10 to 15 percent. We don't really know, but it's at that level that lawyers would call "de minimus."

And it is easy enough for the drug lords to shove in another 10 or 15 percent, another 10 or 15 percent of drugs in the pipeline just as a cost of doing business. So there has been no reduction at all.

In fact, what they frequently do is shove in more than is being interdicted so that while we are interdicting 10 or 15 percent, the 100 percent has gone to 125 percent, so, actually, more drugs are coming into our neighborhoods.

Let me ask all of your law enforcement professionals, at what level of interdiction would there be a serious interruption of drugs into the neighborhoods? Would it be 25 percent? Would that be sufficient, or would the other 75 percent——

Mr. **JOHNSON**. I heard the figure, and I don't know where I heard it from, that if law enforcement interdicted 70 percent of all of the drugs aimed for our shores, drug dealers would still make a profit.

I believe that interdiction alone is not the only answer because they can shove more at us than we can take from them.

Mr. **LAWN**. If I could follow up on that, Congressman, we talk about the success or failures of interdiction. In point of fact, if we miraculously could stop cocaine and heroin from entering the country, we manufacture enough drugs right here in this country to satisfy the appetites of every drug user in the country.

And we should not be pointing fingers at other countries, because we generate the chemicals that go into our clandestine labs. We, in fact, are the cultivators of marijuana.

So the interdiction thing is a part of the effort, but it is not a critical part of the effort.

Congressman **SCHEUER**. Well, I agree with everything that the two of you have said, if you are saying that law enforcement is really not a significant factor here, that it has become irrelevant. Isn't that what you are saying?

Mr. **JOHNSON**. I'm not saying that. I'm saying law enforcement alone is not the answer to the problem. Law enforcement is critical, essential; it should be beefed up, but you cannot do it with law enforcement alone. You need treatment, prevention, education. You need abstinence. You need many things.

Congressman SCHEUER. Okay. I quite agree. There isn't a man with a brain in his head who would say we should wipe out law enforcement. I don't know if any rational person should even say we should reduce law enforcement.

But we have quite agreed that law enforcement alone ain't going to do it.

Mr. LAWN. Yes, sir, but law enforcement is not irrelevant. Law enforcement is critical to this effort. And anyone who says that law enforcement in this effort is irrelevant doesn't understand what law enforcement is doing.

Congressman SCHEUER. Well, maybe the word "irrelevant" was not wisely spoken, but, Mr. Lawn, you would agree that anybody in any town, hamlet, or village in America can get any kind of drug that he wants up to the quantity and quality that he wants?

And I think it was you who said we have never had so many drugs of such high quality at such a low price. Wasn't it you who said that?

Mr. LAWN. I was talking specifically of cocaine, yes, sir.

Congressman SCHEUER. Okay. Cocaine. But when you say that, aren't you really telling us that law enforcement hasn't really made much of a difference?

Mr. LAWN. No, sir, not at all. I can tell you, for example, that law enforcement has seized 1800 percent more cocaine than we did in 1981.

Congressman SCHEUER. Mr. Lawn?

Mr. LAWN. And 44 percent of the federal inmate——

Congressman SCHEUER. Mr. Lawn?

Mr. LAWN [continuing]. Population has been convicted of drug trafficking offenses.

Congressman SCHEUER. Mr. Lawn, that goes back to the business of rating this system on how many busts you make and how much cocaine you pick up and how many arrests you make and incarcerations you make.

What I am asking you, for goodness sake, is to look at another indication, a far better indication of the success or failure of interdiction in what you are doing, and that is to look at what is happening in the neighborhoods.

And when I tell you, and you don't contradict me, that any kid in any town, hamlet, or village in America can get all the cocaine he wants at a higher purity and a lower price than we have ever experienced, doesn't that tell you something about the failure of law enforcement?

Mr. LAWN. That tells me, Congressman, that you are prone to use hyperbole, because that is not accurate.

Congressman SCHEUER. What is not accurate? What did I say that wasn't accurate?

Mayor CALLAHAN. I would like to reinforce——

Chairman RANGEL. If you could hold it just one minute?

Mayor CALLAHAN. No. I would like to——

Chairman RANGEL. Just one minute. The gentleman was sustained.

I would like to advise those in the audience that they are here at the privilege of the House of Representatives and that any display of approval or disapproval of any of the witnesses or the members' statement will force the Chair to ask the Sergeant-of-Arms to have you removed.

Mayor **Callahan**. Mr. Chairman, is this conversation restricted to law enforcement officers?

Chairman **Rangel**. No, it is not, but——

Mayor **Callahan**. Well, I have my two cents' to add.

Chairman **Rangel**. Wait a minute.

Congressman **Scheuer**. My question was restricted to the law enforcement.

Mayor **Callahan**. I am a Mayor that has drugs on the streets.

Chairman **Rangel**. I think we had better recess for 10 minutes. We have another vote on the floor.

[Recess.]

Chairman **Rangel**. I want to thank this panel for the great contribution they have made and see whether there are any other members who are seeking recognition. We've got 10 witnesses locked up in the back room.

Congressman **Scheuer**. Personal, point of personal privilege.

Chairman **Rangel**. Personal privilege? Someone attacked you personally?

Congressman **Scheuer**. No, but somebody questioned my veracity and my knowledge base.

Chairman **Rangel**. Shame. Who?

Congressman **Scheuer**. Jack Lawn said that I was misinformed. I'd like him to explain.

Chairman **Rangel**. Which time?

Congressman **Scheuer**. Where was I wrong, Mr. Lawn? Please enlighten me.

Mr. **Lawn**. Well, Congressman, first you said that law enforcement was irrelevant in this war. That's absolutely inaccurate.

Congressman **Scheuer**. I withdraw the phrase. I will say the effects, the total impact of law enforcement in interdicting the flow of drugs into our neighborhoods, into the arms of our kids, is painfully inconsequential.

Would you object to that?

Mr. **Lawn**. Yes, sir. I would.

Congressman **Scheuer**. All right. Is it grossly inadequate? Would you accept that?

Mr. **Lawn**. This sounds like multiple guess.

Congressman **Scheuer**. Mr. Lawn, look. You really engaged in what I think is an absurd logical anomaly.

Chairman **Rangel**. If the gentleman would yield. I've tried all morning to restrain myself from allowing my emotion to——

Congressman **Scheuer**. All right. I'll try, Mr. Chairman.

Mr. Lawn, you are engaged in what I think is a transparent fallacy of judging the effect of our total government effort to keep drugs out of the arms of our kids by how many busts we make and whether we had more busts this year than last year.

Mr. **Lawn**. No, sir. You said that. I did not say that. That's your anomaly, not mine.

Congressman **Scheuer**. All right.

Chairman **Rangel**. This is really not perfecting the record. Clearly there's a difference of opinion.

Congressman **Scheuer**. I'm going to ask one more question.

Chairman **Rangel**. We've got 10 witnesses in the back room.

Congressman **Scheuer**. I'm going to ask Mr. Lawn a question and the other law enforcement professionals.

Chairman **Rangel**. I wish you would restrict it to——

Mayor. **Callahan**. That eliminates the Mayor, where the problem's on the street, is that right?

Mr. **Lawn**. Well, they may want to come in.

Congressman **Scheuer**. My question is this: Let's say we are all disappointed in the impact of law enforcement on restricting the flow of drugs and the complete availability of drugs in all of our neighborhoods, East, West, North, South. Can you gentlemen think of any re-jiggering of the system, any change in the system, any approach that's new and different that you think might enhance society's devoted wish to keep drugs away from our kids?

Mr. **Lawn**. Absolutely.

Congressman **Scheuer**. Let's hear about it.

Mr. **Lawn**. Well——

Congressman **Scheuer**. And I'm not talking about tinkering around the edges. I'm talking about something that's new and different. I'm talking about taking a trip to the mountaintop and looking at the entire length and breadth of the system by which we're trying to keep drugs away from our kids.

Chairman **Rangel**. Mr. Scheuer, we do not have the time for the trip to the mountaintop. We've got 10 witnesses in the back.

Congressman **Scheuer**. Okay.

Chairman **Rangel**. If you have any——

Congressman **Scheuer**. All right. Listen.

Chairman **Rangel** [continuing]. Ingenuous ideas, the record will remain open.

Congressman **Scheuer**. Let the gentleman answer.

Chairman **Rangel**. And I'm trying to respond to your point of personal privilege.

Congressman **Scheuer**. Okay.

Chairman **Rangel**. I think you're held with the greatest respect among the members of this Committee as well as from the members of the panel.

Congressman **Scheuer**. The gentleman was ready to answer my question.

Chairman **Rangel**. I know. They all are ready. But there's another panel that has to testify and I'm asking them if they would restrain themselves. If you have any ingenuous ideas about what we could be doing better, the record will remain open and I wish you would send a personal copy to Congressman James Scheuer so that he could get it first.

Let me yield to Mr. Oxley, who hasn't had a chance to ask any questions.

Congressman **Oxley**. Thank you, Mister Chairman. I noticed that Mayor Callahan may have had some comments on the last discussion. Is that a fair statement?

Mayor **Callahan**. I certainly did. I still do, if I may.

Congressman **Oxley**. Absolutely.

Mayor CALLAHAN. Thank you. We resorted to something that was referred to as "old-fashioned." We put something as simple as foot patrols in our high drug traffic areas.

Now, they didn't walk upon drug deals. But what did happen is they have a new feeling of respect from the people in the community. And what that did with our administration is that the people in the community started calling in on our hotlines.

And by the way, we don't take phone numbers, we don't take names, we don't take addresses. And they told us where the dealers were, what time the dealers were going down and what kind of cars they drove.

And our local and county law enforcement agencies responded. And, sir, we've made a very dramatic change in our city. Yes, we still have a drug problem. And, yes, we have a long way to go. And, yes, law enforcement is necessary and needed, and it works in the City of Annapolis.

Congressman OXLEY. I thank you for your statement, and I do appreciate it.

Mr. Lawn, you've been before this Committee a lot of times. And I'm sorry I was gone for part of that time for a vote in another committee, but the subject of the day is legalization of drugs.

I assume you are against that?

Mr. LAWN. Yes, sir.

Congressman OXLEY. I also assume you supported most of the major amendments offered in the omnibus drug bill that the Congress debated for about three weeks?

Mr. LAWN. Yes, sir. I did.

Congressman OXLEY. You obviously feel that there are some opportunities for law enforcement that only the Congress can give in terms of expanding your ability, as well as the other law enforcement agencies.

I wonder if you could expand just briefly on those tools that would be helpful if we are to successfully pass an anti-drug bill this year, besides the extra funds, obviously, that are almost self-explanatory, but other areas that you feel can be helpful in the war on drugs.

You are the point man in the war on drugs. We respect and admire the work that you have done. What else could we do, or have we done in the drug bill that could be beneficial in law enforcement?

Mr. LAWN. Congressman, I think the law that we have, the support that we've gotten during the '80s on drug legislation has been effective. I think we do have the tools necessary.

But obviously, you called upon the critical element, resources. I think that we will see greater emphasis placed on the international side, those countries, those source countries that are begging for assistance.

We should be in a position to render assistance in reducing the cultivation of coca, in reducing the cultivation of opium poppy, those kind of things, but that does not require legislation.

Congressman OXLEY. I questioned a previous witness who had stated that we were losing the war on drugs, or we in fact had lost the war on drugs. I don't think either you or, certainly I, believed that, but I also think it's important to try to quantify it.

And I tried to bring that out in that witness, as to where we draw the line. When do we win the war on drugs? Is it when we totally eliminate drugs from the face of the earth? I think that's perhaps a bit unrealistic.

Where would you consider us to be, let's say, five years from now in the war on drugs? What would you consider it to be, what kind of position would we be in to actually declare that we have won the war, recognizing, of course, that we're not going to totally eliminate drugs in our society

Where could we be during that time period? Where should we be?

Mr. LAWN. I would certainly like to see an environment of drug-free schools. And I think that is doable. Because I am very concerned about our young population that has grown up in this drug culture that will never be contributing members of our society. I think that within five years, the drug-free school is doable.

I think the citizen support that is now being generated through the communities, and hamlets of our country will see to it that there is drug-free work places. I think that is doable.

I think it's a tragedy, as mentioned earlier, when if a member of my family is ill and I am looking to take them to a doctor that I'm not sure that doctor is not drug-free, because of the surveys done about the medical profession or when I travel, that the pilot flying that aircraft is not drug-free. I think those things are doable.

Unfortunately, there will be an element of our society who will suffer and will probably perish because of the drug epidemic. That's a reality, unfortunately, because that's a part of this equation.

Congressman OXLEY. I appreciate your comments, particularly the reality part. I think the Mayor shares that same dose of reality.

Mr. Chairman, I had a good discussion with a constituent the other day about the whole drug problem. He's a lawyer and he follows these issues quite well, and he's very articulate about the whole drug problem.

And he said, "You know, there are two easy answers to this, neither one of which are practical, but they are easy answers. The first is legalization, and the second is invasion of foreign countries and wiping out the crop," neither of which, I think——

Chairman RANGEL. Mayor Barry recommended that.

Congressman OXLEY [continuing]. Rational people really accept. And to that extent, that's the easy part. The difficult part is the things we're trying to deal with, you in the law enforcement community, Mayor, you in your position as Mayor of the capitol city of Maryland, all of us on this Committee.

I really do think that points out how difficult, how multi-faceted this problem is. No easy solutions. Anybody who says there are, really, I don't think, recognizes reality for what it is.

And I thank the Chair for its indulgence.

Chairman RANGEL. Mr. Towns from New York.

Congressman TOWNS. Thank you very much, sir. I appreciate it.

And I'd like to ask if there is anyone other than my friend from New York, Brother Johnson—in New York, we're preparing to give out hypodermic needles. I would like to get your reaction to the free-needle program.

Mr. LAWN. Yes, sir, I like Sterling. I'm opposed to the program. When this discussion came up in a law enforcement meeting in Great Britain, one of the researchers from Amsterdam said it's a program that does work.

And I said, "Well, I have an alternative to that program. Why don't we just give out some sterile solution so that the heroin addict could then sterilize his own needle?"

And he said, "Don't be ridiculous. The addict wouldn't waste the time to sterilize the needle." And I said, "Well, I think you've just answered your own question regarding the effectiveness of giving out sterile needles."

I think it is a mistake. I think it gives a bad message, and I don't think it will be successful because it hasn't been successful where it has been tried.

Congressman TOWNS. Thank you very much. No further questions.

Chairman RANGEL. Mr. Gilman?

Congressman GILMAN. Thank you very much, Mr. Chairman.

Mr. Lawn, there was some prior testimony at this hearing and a prior hearing about the drug maintenance program in Great Britain and in the Netherlands being successful.

Could you comment on what you know about those drug maintenance programs and have they truly been successful?

Mr. LAWN. No, sir.

Congressman GILMAN. What has it done to the crime rate?

Mr. LAWN. They, in fact, have not been successful. There has been much written about the so-called "British Plan." The British Plan has failed. It has utterly failed. The very influential magazine, "Lancet," in 1981, talked about the failure of that system.

The heroin addict population has increased by tenfold. The crime rate has gone up substantially. It is a plan that failed and so bad a failure was it that we had members of the legislature in Britain come to the United States to discuss with us new laws so that they could address the drug problem differently.

And those laws were passed. And anyone from Britain who was part of that program will certify to the fact that it was an utter failure.

Congressman GILMAN. Mr. Lawn, in the Netherlands we keep hearing about how that program of tolerance has been so successful. It seemed to me when our Committee visited the Netherlands and visited Amsterdam and took a look at some of those areas, we heard a different story, that it increased the crime rate and that the municipal officials were turning things around once again and taking a hard look.

Can you tell us what your information is with regard to the Netherlands?

Mr. LAWN. Yes, sir. The most recent information that I saw is parallel to what you have just said, that the crime rate is increasing, that the deaths associated with heroin use are increasing, young people from Germany, from other countries who travel to the Netherlands for heroin are dying of overdoses or suffering from overdose problems.

Clearly, things are not getting better in the Netherlands.

Congressman GILMAN. Both of these experiments since legalization or at least partial legalization have really not worked, have they?

Mr. LAWN. No, sir.

Congressman GILMAN. I guess one of the major motivations for the legalization argument has been that we really are not making as much progress or any progress in our war against drugs, and yet, this Committee that's been doing a great deal of oversight sees a lot of sunlight out there on the horizon, sees a lot of progress in many areas.

You're an old-timer in the battlefield. I'd like to ask both you and Sterling Johnson, with all the frustrations and problems that you see, do you see any improvement in the battle over the past year or two?

Mr. LAWN. Yes, sir. I for one can talk about a visit to Peru, where we met President Garcia. President Garcia said that while there are a number of differences that his country has with our country, that he wanted to be known, however, as the President who did something about the coca cultivation in Peru.

It is a problem, a major problem. It is a predominant source country. And the efforts that are ongoing in Peru, the efforts that are ongoing in Bolivia, and in Colombia, clearly give me hope that we will have some successes in the area of cocaine in our country.

Mr. LAWN. You joined with us, Mr. Lawn, when both Mr. Rangel and I and some other members of the Committee were at the International Conference on Narcotics in Vienna.

And it seemed to us at that time that we were hearing for the first time a very strong international cooperative effort being made. What is your impression of what's happening out there in the international community?

Mr. LAWN. That clearly is the case, Congressman Gilman. In 1980 there were two countries involved in eradication. Now there are 25 countries. I recently visited the Soviet Union at the request of the Soviet government. They are very concerned about their increasing drug problem.

Congressman GILMAN. And up to this year, we heard very little out of the Soviets with regard to any recognition of the problem.

Mr. LAWN. Yes, sir. They had indicated to me that their problems began to escalate in 1974, but they refused to acknowledge that there was a drug problem, because drug problems are problems only associated with capitalistic societies.

The People's Republic of China is very concerned about the opium problem, and worked very closely with agencies throughout the world; in point of fact, worked very closely with the Drug Enforcement Administration on a heroin case and sent one of their prosecutors who is currently, I believe, in California, giving depositions.

It is clearly an international problem, and clearly, countries are addressing it very, very seriously, where this was not the case five years ago.

Congressman GILMAN. Mr. Johnson, I know you've been frustrated on many occasions and you appeared before our Committee and described the backlogs of cases and the lack of personnel and the lack of resources.

Have you seen any improvement at all or any hope out there in the manner in which we are beginning to address some of these problems?

Mr. JOHNSON. The resource problem is still a very serious problem and as far as prosecutors are concerned, particularly my office. I still have only 70 prosecutors.

And I still am under-funded in New York. I am funded by the state and the city. And the city points a finger at the state and the state points a finger at the city.

But I must add that I'd like to take Jack Lawn's statement a little further. I see a terrific cooperative atmosphere in New York City with local law enforcement and federal law enforcement, a tremendous amount of cooperation with the Drug Enforcement Administration, the F.B.I., the State Police, and we are making tremendous amounts of cases, securing tremendous victories, convictions. They still keep coming, but we never saw this five years ago.

Congressman GILMAN. Just one last question of the panel, the entire panel. One of the major arguments in legalizing has been that once we legalize we're going to reduce the crime, reduce the amount of expense needed for enforcement. What is your response to that argument?

Mr. EADS. Not on a local level. No, sir.

Mr. JOHNSON. No. That's not going to happen. You're still going to have people who are going to have and use drugs. No matter how good we get, bad guys get better.

In 1981, I think, we had something like 50 tons of cocaine coming in. The Select Committee says in 1987 they estimate about 180 tons of cocaine coming in.

Since that time, when we had the influx of cocaine, people learned how to make crack. And that's creating just independent, serious problems for us. So it's going to get worse.

Congressman GILMAN. Mr. Lawn, would you care to comment on that last question?

Mr. LAWN. Yes, sir. Legalization serves capitulation. Many of the proponents of legalization have said, "Well, if we can just put very stringent controls on these illicit substances the way we have on licit drugs."

In point of fact, our D.A.W.N. statistics, the Drug Early Warning Network, the drug information we receive from 700 hospitals each year, the D.A.W.N. statistics tell us that last year, 75 percent of those people seeking treatment for drug overdoses were using licit drugs improperly.

So if anyone wants to balance the fact that taking an illicit substance, making it legal, would prove helpful, we can see from the problems associated with licit drugs that it's not working with licit drugs. We even have to have more stringent policies.

Congressman GILMAN. Thank you. Any of the other panelists wish to comment on that question?

Mr. VAUGHAN. As I pointed out earlier, we believed that the assumption that crime is going to either be substantially reduced—I've not heard anybody say "eliminated"—because we legalized drugs is naive.

There was crime before there was the drug problem of the magnitude that we know it. There will simply occur a process of displacement. A new enterprise will develop in its place, a new criminal enterprise.

So it's not as those who promote legalization would have us believe, that it's going to be the solution to the crime problem. We'll just have a whole new set of crime problems.

We can reduce the amount of drug-related crime through comprehensive, cohesive strategies, but it's not simply reduce all the crime and say it was caused by drugs.

Congressman GILMAN. Thank you.

Chairman RANGEL. Let me thank this panel.

Congressman GILMAN. Thank you, Mr. Chairman.

Chairman RANGEL. Thank you, Mr. Gilman, for the contribution that you've made. I think the entire Select Committee agrees that law enforcement certainly has fulfilled or is upholding their part of the contract.

And I think what Jim Scheuer has been saying over and over again is that we have to do more than just law enforcement. All of you totally agree.

With all due respect to the great work being done by the Drug Enforcement Administration in terms of going out there, investigating, making the cases, getting the convictions and putting these scoundrels in jail, I think they need more help if they are going to be involved in educating as well.

They should not have to do this as a part of their regular responsibility, even though it's a tribute to those who do it. But we have to get out there with education. We have to make certain that anybody who wants treatment can get treatment.

And I think it's safe to say that when we talk about the homeless, the jobless, the skill-less, and those without hope, that Government in general has to be there to shore up those people who find drugs an easy way out.

I would like to believe—I'm glad to hear that you feel there is some hope overseas. I haven't seen it. This Committee has that high as a priority. But we don't see where drugs really has reached that point as a part of our foreign policy where it should be.

Indeed, the indictment of Noriega at this late stage of the game clearly indicates to me the fact that it was not a high priority.

In any event, please continue to join with us, as the Mayor has pointed out, in trying to get a comprehensive program. It's not just a question of putting people in jail. It's a question of educating them, it's a question of getting the resources and making it truly a health problem.

It's been an outstanding panel and this Committee will have questions and I hope that you'll be kind enough to respond to them. Thank you very much.

Mr. LAWN. Thank you.

Chairman RANGEL. The last panel is a very, very large panel and we can take a little break while they come out and be seated here, while staff invites them out and once you set up—we will just take a five-minute break here.

[Recess.]

Chairman RANGEL. The Committee will now come to order. Let me thank this panel for its patience and I understand that Dr. William Chambliss from George Washington University has a time problem and he shared that with his colleagues. So why don't we start with his testimony?

As I indicated or as staff has told you, we will have a five-minute rule. Your entire statements will be entered into the record. And this will afford the Committee members an opportunity to ask you other questions.

TESTIMONY OF WILLIAM CHAMBLISS, PH.D., PROFESSOR, GEORGE WASHINGTON UNIVERSITY

Dr. CHAMBLISS. Thank you, Mister Chairman, and thank you for the opportunity to appear. I think it's been a very enlightening day for all of us.

Probably there are a few things that we could all agree upon on the basis of what has been said before. One of them is that in the best of all worlds we're not going to live in a perfect society. We're not going to live in a place that's drug-free.

It's clear that what we've been doing has not had the results that we would want it to have or we wouldn't have to hold these hearings. And it's equally clear that there is a great difference in opinion as to what the value would be in trying a different system other than the one that criminalizes people who use or distribute and sell drugs.

In 1938, it was estimated that there was a business in drugs of a billion dollars a year. Fifty years later, in 1988, that business is $130 billion a year, which means it is a gross volume of business that is larger than the gross national product of most nations in the world. It's a gross volume of business that's larger than any multinational corporations gross volume of business.

To create that much business and to manage that much business requires an incredible organization and an incredible amount of cooperation.

What we haven't seen talked about today, but seems to me is crucial to the whole discussion is the issue of what it costs to criminalize drugs, and what it costs is far greater than what we have recognized or paid attention to.

Indeed, in my research on organized crime, which has taken place for over 25 years now, there is one thing that is absolutely clear, and that is that groups of organized crime have a grip on every city in the United States and most cities in the Western World, and that they depend upon the profits from drugs to hold that grip. And the profits from drugs are immense.

Part of their grip also depends upon their ability to corrupt police departments and corrupt law enforcement agencies. They have never succeeded to the degree that they would like, in that we never find a police department or law enforcement agency that is completely corrupt, but we don't find any that don't have a lot of corruption in them.

And a large part of that corruption, I would estimate 80 to 90 percent of it, comes because of the profits from drugs. It is not surprising that there has not been a decrease in the availability of drugs. It is not surprising because the profits are too high and the ability to transport and move drugs around is too simple. It is too easy, because it is so much profit for a very small commodity.

There is no way that can be stopped by law enforcement. There is no way that it has been. It has grown immensely and it will continue to grow. It can be stopped for a short time in an area, as we have witnessed in Washington, D.C., but the drug pushers will move to the area next door.

If you were to go out in Washington, D.C. tomorrow morning or tonight and arrest every drug pusher in Washington, D.C., I guarantee that what you would do would be to create new jobs for people who are not now drug pushers.

We have a population of 20 percent of the people who live below the level of poverty and they are willing, very willing, and eager to replace whatever drug pushers have control today. But this is just one of the many, many costs that the present program, the present policies cost us and this society.

It costs us in corruption; it costs us in organized crime and their power; it costs us in lives, it costs us in devastated communities; it costs in devastated families who have no place to turn for help; it costs us in our law enforcement expenses that we've put out to try to do something about it; it costs us in people spreading A.I.D.S. that would not be spreading A.I.D.S. if it were possible for them to get heroin legally, medically administered.

Over and again, you have asked, Mr. Chairman, "What would you propose as a policy?" It seems to me that, first of all, it is incumbent upon the Congress to stop talking about drugs as though they were all the same thing.

Passing legislation that links marijuana, cocaine, and heroin is akin to passing legislation that sets laws up to try to control tricycles as well as automobiles.

Marijuana is a completely different thing from cocaine, and cocaine is a completely different thing from heroin. It has almost been implicit in these meetings, even from the members of the Committee, that marijuana should be dealt with separately. And, indeed, it seems to me that that is the first thing to do.

The experience of the states that have decriminalized marijuana has been nothing but positive. The evidence isn't very good because it is difficult to study. What evidence there is suggests that there is a decline in marijuana use when it becomes decriminalized.

With heroin, contrary to the statements of police officers and others, the experience in Great Britain, although it has not been a complete success, has been far more successful than the experience in the United States of criminalizing heroin.

And, indeed, we should put heroin into the medical profession's hand. And with cocaine, we should do the same.

My time is up, I can see. Thank you very much

[Statement of Dr. Chambliss appears on p. 303.

Chairman **Rangel**. Thank you, Professor.

We will hear Dr. Charles Schuster, the Director of the National Institute on Drug Abuse, before we go vote. Everyone knows that what we are doing is not working.

This is a hearing on the question of decriminalization and legalization. And everyone wants to try something different. But you have to be specific as to what that difference is, and what regulations and controls you are talking about.

And I asked a series of questions at the beginning of this hearing, but everyone is talking about commissions and studies. Well, you come here, especially those who have had the opportunity to research and study this, and tell us the results of those studies.

Dr. Schuster?

Congressman SCHEUER. Mr. Chairman, may I ask a question? Wouldn't it be appropriate for any of the witnesses to suggest anything that we ought to be considering, any option, any alternative, any new direction from the present failed system?

Must they restrict themselves to the "L" word and the "D" word? Can't they just——

Chairman RANGEL. Well, that is the reason for the hearing: legalization and decriminalization. Now, if they'd want to go to the top of the mountain and come up with something else, then they can do that. It is not restricted, but that is why we are here.

And I was pleasantly surprised that you shared with me that you oppose legalization and decriminalization.

Congressman SCHEUER. I didn't say that. I'm not for them, but I am interested in hearing from these expert witnesses——

Chairman RANGEL. Well, let them talk——

Congressman SCHEUER [continuing]. All possible alternatives to the present system.

Chairman RANGEL. Well, let them talk about legalization and decriminalization so that you can make up your mind whether you are for or against it.

Congressman SCHEUER. Supposing they have another alternative to suggest that is a constructive departure from the present system?

Chairman RANGEL. Well, then, we will just have another hearing. This was called for legalization and decriminalization, and if they had any problem with that, they wouldn't have accepted our invitation to testify.

Congressman GUARINI. Mr. Chairman, may I just inquire from Dr. Chambliss? I know you hadn't completed your statement. Is Dr. Chambliss here?

Chairman RANGEL. He is gone.

Congressman GUARINI. I just want to know what his recommendation was about legalization or decriminalization, because he was laying his foundation and never got to the point of reaching his conclusion.

Chairman RANGEL. He is gone. It is in his written testimony. It would help if we could get to the conclusions first, as to whether you support legalization or decriminalization or the study or the debate or the look into it or the alternative, whatever.

Dr. Schuster?

TESTIMONY OF CHARLES R. SCHUSTER, PH.D., DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE

Dr. SCHUSTER. Thank you, Mr. Chairman and members of the Committee. I am here representing both the National Institute on Drug Abuse and the Department of Health and Human Services.

I will say at the start that the National Institute on Drug Abuse and the Department of Health and Human Services strongly oppose legalization of drugs of abuse.

Now, as you know, the National Institute on Drug Abuse is the lead federal agency charged to conduct research into the nature and extent of our drug abuse problems in this country; methods of preventing drug abuse through school-, community-, workplace-, and media-based prevention programs, and the development of methods for the treatment of those who, unfortunately, have become addicted.

Let me reiterate again that we at N.I.D.A. and H.H.S. are strongly opposed to the legalization of drugs. But in the interest of time and to prevent redundancy, I will highlight only a couple of the reasons which have led us to this conclusion.

Although we strongly oppose legalization of drugs, we recognize the frustration and desperation felt by those who support this move. As someone who has worked in the area of drug abuse, both in the laboratory and in the clinic, for 30 years, and as a parent whose family has been affected personally by the tragedies of drug abuse, I understand the need and the drive to seek new solutions to this problem which, at times, appears to be overwhelming us.

But I do not believe that legalization will have the positive results its proponents envision. As Mr. Rangel said at the beginning of this meeting, there are a series of questions which would have to be dealt with prior to the time that we could consider legalization.

I would simply wish to point out that my knowledge of pharmacology shows that the issues are even more complicated than the Chairman has said. We know, for example, that the differences in the pharmacology of cocaine and heroin make it virtually impossible for us to consider legalization of cocaine.

What do I mean by that? We know that a heroin addict takes the drug three to four times daily. After receiving an injection of heroin, at least for a brief period of time, the craving for this drug is satisfied.

But that is not how cocaine works. Our laboratory experiments and our experience on the streets have shown an injection or a snort or a puff of crack increases, rather than diminishes, the craving for cocaine.

I would compare it to the experience which we have all had with salted peanuts. As long as you don't touch them, it isn't so bad. But the minute you have one, it is darned tough to resist going back for more.

So what would we do if we were going to legalize cocaine? Would we have government-sponsored clinics in which drugs could be given every 30 minutes around the clock?

Who would end this cocaine spree? Would it be the addict who said, "I had enough"? That is not likely. Experience has shown that as long as cocaine is available, most cocaine addicts cannot regulate their intake, they continue to take it until they either have a convulsion or a heart attack or, more likely, they run out of the drug.

If the dispenser were to say, "No, we are stopping you now," in this condition in which craving has been stimulated, it seems to me likely that the individual will then go out on the street and seek more cocaine.

Therefore, I don't see that the hoped-for decrease in cocaine distribution networks would be as great as the proponents of legalization visualized.

I would also like to point out that drug abuse in the United States is still, if not our number one problem, one of the top two or three, but we are making progress.

We conduct a high school senior survey every year. And for those in their senior year of high school, we are seeing a change in attitudes in which drugs are being perceived as more dangerous. Perhaps even more importantly, we have seen a large change in terms of self-reported drug use.

In 1978, 11 percent of our high school seniors reported that they used marijuana daily. That is 11 kids in 100. That is down to 3.3 percent in last year's survey. This is a significant decrease.

Similar figures exist for P.C.P. Even with the most intractable of drugs, cocaine, we have at least seen some downturn in the past few years.

So we are making progress. I think it would be a poor time for the federal government to send out a signal that we are tossing in the towel by legalizing drugs and giving up on the issue.

I think attitudes are changing in our adult population as well. It is simply not as fashionable any longer to light up a joint at a party or to consider snorting cocaine. We know that as attitudes change, behavior will not be far behind.

I would not disagree that there are still areas in our country where drug abuse problems are overwhelming, but legalization is not the answer. I think legalization would simply harden the problem and preserve it.

For those who are addicted, we do have effective treatment. There are good treatment programs. I'm not saying that all treatment programs are effective, but we know that good treatment works.

What we need to do is ensure that good treatment programs are available for all of those who need it. Further, we need an active outreach program to encourage people who need it but who may be reluctant to try to get into treatment.

We know this will work. We know we can have this kind of outreach. And we know if we get people into treatment, we can have a positive impact on their lives.

I think that before we toss in the towel and say that we should legalize these drugs, we should really give prevention and treatment a good try. I hope that the National Institute on Drug Abuse and all the public and private sector individuals who are involved in prevention and treatment are going to redouble their efforts because of this debate, faced with the idea that legalization is being seriously proposed.

I think it points out to us that we must redouble our demand reduction efforts, not that we are going to legalize drugs.

Thank you.

[Statement of Dr. Schuster appears on p. 308.]

Chairman Rangel. Thank you. I agree with everything you say, but I don't really think it is being seriously proposed.

Dr. Arnold Trebach, founder of the Drug Policy Foundation. Doctor, it's not seriously being suggested, is it?

TESTIMONY OF ARNOLD S. TREBACH, J.O., PH.D., PRESIDENT, DRUG POLICY FOUNDATION; PROFESSOR, AMERICAN UNIVERSITY, WASHINGTON, DC

Dr. Trebach. Congressman Rangel, first let me say this. I want to congratulate you for holding these hearings. I want to congratulate your staff. I am delighted to participate in this bit of history.

I think you are prepared to hear the other side, and I know how passionately you feel we are wrong.

Chairman Rangel. I have an open mind.

Dr. Trebach. And you have convinced us—pardon me?

Chairman Rangel. I have an open mind on this, Doctor.

Dr. Trebach. All right. Let's put it this way. There is a lot of passion on both sides, sir. But I think we are at our best when we calmly look at the facts.

Quite frankly, if we were to change all the drug laws tomorrow morning and get rid of them, I would feel we would be better off. I would be scared about that, but I think if I compare it to the direction we are now going, if I had a choice, I would opt for total legalization of all drugs.

But I don't think that is going to happen. So, as a result, I look for compromise points. Now, some may say "Well, you don't really seriously believe in legalization."

Let's say this. I believe that Americans are at their best when they negotiate settlements. They are at their worst when they push arguments to the wall. I am trying to look for the points where we might find possible agreement.

However, I listen to you, and I am listening to you now. And I am going to try to pick out those points that might involve change. So I am departing from my statement, and this might be a bit choppy, but I am going to go down those points and get to the bottom line, as you have asked, sir.

Chairman Rangel. Thank you. Your entire statement will be made part of the permanent record.

Dr. Trebach. Thank you. I just want to pick out these points that involve various forms of legalization or decriminalization. First, I think it is absolutely essential that we change the law regarding the use of marijuana and heroin in medicine.

Now, that is not total legalization, but it would involve a change in current law. I happen to be co-counsel on one of the suits seeking to make marijuana available in medicine.

And one way that could be changed is if Mr. Lawn, the head of D.E.A., just signed his name on a piece of paper because he would just have to go along with the decision of his Chief Administrative Law Judge to make marijuana available in medicine. So that is one point of change. It is not enormous, but it would make an enormous difference to many people. Also, Congress could pass a law making marijuana and heroin available by prescription in medicine.

It would mean that doctors could prescribe marijuana and heroin to patients suffering from cancer, glaucoma, multiple sclerosis, and so on.

Second point of change: We should attempt to start looking at addicts differently. Now, these are many addicts who really are very despicable characters. They are robbers. They pollute our cities. And they deserve to be treated very harshly.

However, I think we should change our approach, attempt to provide them the widest possible array of treatment options, including in some circumstances the approach used very successfully, despite what you have heard from other witnesses, very successfully, in this world of imperfection, in England and in Holland.

That would mean in some cases, they would get medicinal heroin. They also might get all the other narcotic drugs. However, I do not advocate cocaine maintenance. I don't advocate alcohol maintenance, but we could change the law to allow doctors to prescribe, not just arrange drug-free treatment, but also narcotic maintenance treatment for addicts.

There are enormous problems in that. And I am willing to take the questions later. But that would involve legalization to an extent, a change to the law on that.

I think we should also experiment with limited decriminalization or "legalization," if you will, of recreational drugs. And, again, I would follow the Dutch model on this. The Dutch model has been much maligned, and I think that we ought to take a look at it.

Let me depart for just a second. Could the Drug Policy Foundation have permission to later submit a memorandum summarizing the Dutch system and the English system, which might present it in a different light, sir?

Chairman **Rangel**. Without objection.

Dr. **Trebach**. Thank you. On decriminalization of marijuana, I would also follow the reports of two of the latest American national commissions, President Nixon's Commission on Marijuana and Drug Abuse in '73 and the National Academy of Sciences report in '82.

Put them together. In a nutshell, they say, attempt limited decriminalization, even legalization of possession. Legalization of possession is possible, and even legalization of sales where no profit has been involved.

Those are extraordinarily powerful recommendations, and, yet, so limited in certain ways. They have been totally ignored. I think that is a good place to start.

Often, you can downplay marijuana and say, "Well, that doesn't count." But the largest single group of arrests in the war on drugs involved marijuana possession, and I think we could make enormous inroads there if we attempted to make that change recommended by two national prestigious commissions.

One final point. Use and abuse, will they rise destructively if you change the law? If you change the law regarding the use of these drugs, there is a risk of a rise in use. Any reformer who doesn't face that is being a fool. There is a possibility and a risk, and I worry about it.

But when I look at all of the available evidence, including evidence from the National Academy of Sciences, I think the risk is worth it, because when I put all the evidence together, I see the possibility of a risk, but not the probability of an enormous rise.

That is a summary of my statement, sir, and I make myself available for questions.

[Statement of Dr. Trebach appears on p. 314.]

[Memorandum on Dutch and English systems submitted by Dr. Trebach follows his prepared statement.]

Chairman RANGEL. Thank you.

Admiral Watkins, Chairman of the President's A.I.D.S. Commission. It is really a great honor to have you testify in front of us today and to give me an opportunity to thank you and your entire Commission for the great contribution they made to this problem of A.I.D.S., which still we find ourselves in the Middle Ages in terms of understanding.

But you broke through a lot of tradition in order to find the depth of the problem and then you came with some hard-hitting facts and made a challenge to the Congress and, indeed, the nation.

And I certainly hope that we can catch up to the leadership and the direction that you provided for us, and I am glad that you are able to share your thoughts with us today.

Admiral Watkins?

TESTIMONY OF JAMES D. WATKINS, CHAIRMAN, PRESIDENT'S AIDS COMMISSION

Admiral WATKINS. Thank you very much, Mr. Chairman.

I am honored to be here before this particular Committee hearing on the decriminalization of illegal drugs. Obviously, as you read in our Commission report, we are for other things. We would not be, and I think I can speak for all of the Commissioners, for the decriminalization of drugs.

On the 24th of June, we reported out to the President of the United States on actions to deal with the insidious epidemic of A.I.D.S. The Commission conducted 45 days of in-depth hearings, collecting information on the epidemic from experts throughout the nation. We listened to them. What I am going to tell you today is basically what they are telling us in this whole area.

The Commission realized that the H.I.V. epidemic, early in deliberation, was inextricably intertwined with the drug abuse epidemic. Several of our Commissioners asked, "Are we the Drug Commission or the A.I.D.S. Commission?"

Some statistics should illustrate this point. Intravenous and other drug abuse is a substantial conduit of H.I.V. infection, as you know, a major "port of entry," if you will, for the virus in the larger population.

Although I.V. drug abusers constitute only 25 percent of the A.I.D.S. cases in the United States, 70 percent of all of the heterosexually transmitted cases in native born citizens comes from contact with this group.

In addition, 70 percent of the tragic para-natally transmitted A.I.D.S. cases are the children of those who abuse intravenous drugs or whose sexual partners abuse intravenous drugs. And the situation as rapidly worsening as the number of infected drug abusers grows daily.

In addition to the direct threat of transmission from the needle and paraphernalia-sharing, the Commission was repeatedly told that alcohol and drug abuse and all of their manifestations impair judgment and can lead to the sexual transmission of H.I.V.

After extensive hearings on the link between drug abuse and H.I.V., several themes emerged. First, the drug treatment system in this nation is seriously inadequate by any rational standard, but especially so in this era of A.I.D.S.

With an estimated 1.2 million intravenous drug abusers, at any given time no more than 148,000 are now in treatment. This lack of treatment availability led the Commission to call for a massive, long-term commitment to treatment availability.

And it was not for purely altruistic reasons, but to stop the rampant spread of the H.I.V. by getting these people under our compassionate wing and taking the steps necessary to get most of them to stop using drugs.

Equally important, however, was the repeated call by our witnesses to seek a change in societal attitudes which permit drug abuse. They implored us to inspire leadership from national and local levels to create drug-free communities, urging that special attention be given to prevention programs.

What is needed, according to all of the experts who appeared before us, is a coordinated, full-scale effort which addresses both supply and demand, with equal attention to prevention, education, treatment, research, interdiction, eradication, and full enforcement of our criminals law, and for a sustained period of time.

In a discussion analogous to the one we are having today, voices were raised seeking the provision of clean needles for addicts as a means for curbing the spread of the H.I.V. epidemic.

And I raise this issue today in these hearings because many people feel that a provision of clean needles by government-sanctioned programs is the first step toward actual government sanction of the use of illegal drugs.

The H.I.V. Commission heard extensive debate on this issue, including those from foreign sources. Earlier this year, three of my fellow Commissioners and I attended meetings in Harlem and metropolitan hospitals in New York. We spent two days with representatives of 22 churches in the region, several senior black officials, and a special narcotics prosecutor for the five boroughs of New York City who was a witness before your Committee here today.

They had much to tell us, but all—and I mean all—said that I.V. drug abuse was killing their community and all were bitterly opposed to needle exchange as a means for dealing with this problem.

And why? Because they viewed clean-needle programs as a cop-out. They see them as diversionary tactics that only mislead the uninformed that cheap, quick, mechanical fixes can somehow work, thereby avoiding costly alternative decisions.

At best, they view such programs as stop-gap measures that will surely fail to get addicts into treatment, fail to stop the epidemic, and fail to protect babies that are being born with H.I.V.

But more importantly, these black leaders are dead-set against needle-exchange programs because they feel these programs work directly against the efforts of many, including those of you like yourself, Mr. Chairman, to keep our men and women sliding deeper and deeper into drug addiction and deeper into despair, instead of getting them into treatment and off drugs for good.

They say it sends a message that drug addiction is okay as long as it is clean drug addiction. I suggest a visit to Harlem Hospital if anyone here is in any doubt about the horrors of drug addiction, even without A.I.D.S.

Better, they believe, as do I, that we must extend our hands much further in order to reach into those communities, pull our young people out of their lives of hopelessness, and then, through jobs and education, give them the tools to truly be in the mainstream again in our society and keep their hopes alive.

Mr. Chairman, as a nation, we have not yet done our job on the positive side to provide adequate treatment and prevention programs. As the H.I.V. Commission recommended, let us, as a nation, commit ourselves to a sustained effort. We said 10 years to provide treatment on demand for drug addicts and education for all Americans, as well as stronger criminal sanctions for those who profit from drug trade.

If such an all-out effort fails, then 10 years from now, we can begin to talk about whether we want the government to sanction the drugging of some of its own citizens.

But let's make the effort first and not chance the write-off of too many of this nation's most precious resources, our young people.

In short, the message the Commission heard was not decriminalization, but make the necessary commitment to prevention, education, treatment, and supply reduction in a real way. "Get off the rhetoric," if you will, and put your money out there, because it is both cost-effective as well as humanitarian.

It is for these reasons that I strongly oppose efforts to decriminalize illegal drugs. Instead, we need to mount an all-out effort to treat those addicted and get them off drugs while preventing our young people from ever starting to abuse them in the first place.

Helping our young people to avoid abusing drugs in the first place is, in my opinion, the essential ingredient to survival of our democracy in the next century.

Thank you, Mr. Chairman.

[Statement of Admiral Watkins appears on p. 366.]

Chairman RANGEL. Thank you, Admiral, and I do hope that the close of this administration will not make you less available to those of us who so badly need your courage and your leadership.

Your statement is an eloquent example of the fine work that has been done by the Commission. President Reagan was fortunate to have you to be available, and so was the nation. And I do hope that as we place your statement in our Congressional record as well as this record, that a close of this political period will not mean we will not be working together in the future.

Admiral WATKINS. Thank you, Mr. Chairman.

Chairman RANGEL. Thank you very much.

Tod Mikuriya, M.D., a Berkeley psychiatrist, I would hope you would correct me in the pronunciation of your name?

Dr. MIKURIYA. Perfect.

Chairman RANGEL. Thank you very much.

TESTIMONY OF TOD MIKURIYA, M.D., BERKELEY PSYCHIATRIST

Dr. MIKURIYA. Chairman Rangel, members of the Committee, I am really gratified to be here to be able to participate in this historic discussion.

It is, indeed, exciting as a physician to witness the increase in public awareness that tobacco and alcohol are also drugs and the most dangerous ones at that.

One of our big problems is the differences in perception as to what drugs are and what drugs are not. What is a drug? Definitions are quite different for different people.

As physicians, we are appalled at the debate going on over at the F.D.A. over the smokeless cigarette issue, as to whether or not this constitutes a drug. It is.

And our drug education heretofore usually consists of being inundated by advertisements for over-the-counter nostrums to try to treat every kind of ailment known to us plus uncomfortable, unaesthetic conditions.

And it is really incomprehensible to believe that this society; that is, quote, "educated," with this kind of information can ever realistically hope to have a drug-free condition.

We are talking about not being drug-free, but freedom of the right drugs or wrong drugs. And these "right drugs" or "wrong drugs" definitions are flexible, depending on who is defining them and what the purpose is.

The big difference between the public opinion and reality that is discussed and what the actual toxicity of these drugs are continues to be a significant problem for us in the medical profession because, although these drugs like cocaine and the refined cocaine, crack, get a lot of attention, little attention is paid to all the people that are sick from alcohol poisoning and tobacco poisoning.

There is this fragmented reality where one world does not relate to the other. And this is what needs to be changed. And I think that the public is ready to accept a comprehensive drug proposal.

And to that end, I did actually prepare a fairly elaborate specific set of responses to those questions that you posed in your invitation to this hearing.

I was fascinated in this discussion as it closed on the program "Nightline," where you continued to press this sort of question. And I was thinking to myself, "Boy, I wish I could answer." And here I am.

The six points of this comprehensive drug proposal are to:

Remove product liability exemptions for alcohol and tobacco;

End price supports for tobacco prices;

Set up voluntary drug users' cooperatives, (and that will take some elaboration later, perhaps during the questioning period);

Legalize home cultivation of cannabis;

Forbid warrantless searches of citizens; and also, finally,

Test those who test others for drugs.

We are dealing with a problem in lapse of moral imperative: of being able to pull off the kind of moral leadership that we need for a campaign on drugs. When we have people at the top that are dealing from the bottom of the deck, that is what leads to this malice in blunderland, which the current drug war constitutes.

There is no rationality in this because of these different plastic definitions of what is "dangerous," what are "drugs," and what are "proper uses."

And until we have an overall drug policy that takes all of these into consideration, we are just going to have more of the same repeated single-substance-oriented news stories that proclaim that the next drug will bring society to its knees, only to be supplanted by the next seemingly attractive substance to the public for their outrage.

I think that I probably used up my five minutes. Thank you.

[Statement of Dr. Mikuriya appears on p. 373.]

Chairman **Rangel**. Thank you, Doctor.

John Gustafson, Deputy Director, New York Division of Substance Abuse Services?

TESTIMONY OF JOHN GUSTAFSON, DEPUTY DIRECTOR, NEW YORK DIVISION OF SUBSTANCE ABUSE SERVICES

Mr. **Gustafson**. Thank you, Mr. Chairman.

In the five minutes allotted to me, I would like to accomplish three things: one, to briefly sketch, in overview fashion, what my Agency is about; second, describe the impact of drugs within our State of New York; and, third, give you our reasons why we are so opposed to legalization.

I work along with my colleagues, the people-recycling business. We deal with the casualties of the drug abuse problem in the State of New York.

We oversee and regulate a diverse network of some 400 local treatment and prevention programs. On any given day, we have the capacity to treat 46,000 individuals and provide counseling services, prevention counseling services to another 17,000.

In the course of a year, we will provide treatment services to approximately 80,000 and have another 40,000 individuals participate in primary prevention programs.

We have a state budget recently enacted that provides $218 million for this purpose. This represents almost a 29 percent increase over what we had available last year.

I should point out that only 11 percent of these monies come from federal sources, Alcohol Drug Abuse Mental Health Block Grant or A.D.T.R. funds.

New York has historically demonstrated national leadership in the field of substance abuse treatment and prevention, and we contribute approximately three times the national average to this endeavor.

In spite of this extensive network of services that we have in my home state, we have a tremendous problem that is growing every day. Twenty-two percent of our state's population have used substances in the past six months, and half of these use drugs regularly.

Over 600,000 persons are considered heavy, non-narcotic abusers, and 260,000 persons are narcotic addicts in New York. The Mayor of the city of New York in his testimony indicated that approximately 200,000 of those are in the metropolitan New York area. That is accurate.

Rates of substance abuse are much higher among younger age groups, and over the last two to three years, the rates of substance abuse have increased more rapidly than the general population has increased.

A.I.D.S. continues to be a major health crisis. We join in your applauding Admiral Watkins for his leadership in developing the Commission report. As of August of this year, over 18,000 AIDS cases were confirmed in New York. This represents over 25 percent of the 72,000 cases in the country. New York has 34 percent of the nation's A.I.D.S. I.V. drug cases.

The overwhelming intensity of the drug problem is finally becoming clear, leaving some to call out in frustration for us to legalize these very substances which are tearing my home state and us as a nation apart.

The terrible social and health consequences of legalizing argue strongly against adopting such policy. You have already heard the grim statistics, given even the significant increases in our prevention and treatment efforts in the past few years, but consider the possibilities if drugs were freely available to all who want them.

Proponents of legalization ignore the seductively addictive properties of substances that they would legalize. Laboratory animal experiments have shown that given unlimited access to cocaine, animals will continue taking even greater amounts until they die.

Our experience with prohibition is often cited by advocates of legalization. But while prohibition was a law enforcement failure, I submit it was a health triumph. Alcohol-related mental and physical illnesses declined dramatically in the 1920s and then soared after repeal in 1933.

Another example to learn from is our experience in New York with the Whitney Act Clinics. This is a program that very few people in testifying referenced.

From 1917 to 1921 in New York State, narcotics were made available through clinics. When it became clear that the drug users were supplementing their illegal supply from a flourishing, illicit market, the law was repealed.

The impact of legalized drug use on our health care systems would also be phenomenal. For example, we know that the use of crack causes pneumonia, chronic bronchitis, searing of lung tissue, and heart attacks. Chronic use of cocaine can lead to liver and respiratory problems, and also has been linked to mental disturbances.

Medical costs associated with the A.I.D.S. problem for both I.V. drugs users and their babies are already staggering. I can go on and on with other statistics. It would be redundant. You have heard most of them before.

I would like to close with just one observation. We all like to think that we live in a society that is compassionate and caring. Such a society does not engage in public policy that would assist its citizens in committing suicide.

I would be pleased to respond to any questions. I would ask that my full written statement be entered into the record, if there were no objections.

Chairman RANGEL. Without objection.

[Statement of Mr. Martinez was presented by Mr. Gustafson and appears on p. 404.]

Chairman **Rangel**. Professor of Law, NOVA University, Professor Steven Wisotsky?

TESTIMONY OF STEVEN WISOTSKY, PROFESSOR OF LAW, NOVA UNIVERSITY

Professor. **Wisotsky**. Thank you, Mr. Chairman and members of the Committee, for inviting me to testify in these hearings, which I hope will be the beginning of a process and not the end of one.

It seems to me that there were three fundamental challenges issued by the Chair and by members of the Committee throughout the hearings today: to be clear, to be constructive, and to deal with the question of values.

And in my remarks, I hope to do something toward reclaiming what has been called the "moral high ground" on this issue. In 1986, I published a book called "Breaking the Impasse in the War on Drugs," in which I acknowledged that we were stuck between two extremist positions, one pushing for continuous and infinite escalations of the war on drugs, and the other one calling for more or less a collapse or repeal of the existing system.

I proposed at the end of the book a solution that has been voiced here today; and that is, the appointment of an independent national study commission to take a fresh look at the entire question of U.S. drug policy and to be directed toward two fundamental goals.

The first goal is to reduce drug abuse and the second goal, equally important, is to reduce all of the social pathologies that are generated by drug money, by the billions of dollars that are generated in the black market in drug trafficking.

Now, very quickly, in the five minutes allotted, I would give to this Commission a mandate to pursue four directives: number one, to define the drug problem; number two, to state specific goals; number three, to substitute study for speculation; and, fourth, to focus on the big picture.

No one today has defined what the drug problem is. Some people mean that some people are using drugs, drug use per se is the problem. Others refer to drug use by kids. Others refer to drug use that is injurious to the user or to third persons. And still others refer to black market phenomena, crime, violence, and corruption that attend the drug traffic.

We need a clear definition of what exactly is wrong in this country regarding drugs.

Following from that would be a statement of goals. And it is very important, because not all of these goals are achievable. Two of them are fundamentally inconsistent.

If your concern is drug use per se, then you adopt a policy of zero tolerance, you pursue all drugs, and you inevitably create a massive black market that has corrupted law enforcement, generated international narco-terrorism, street crime by addicts, and on and on and on. Priorities must be set. Not everything can be done.

Third point, substitute study for speculation. People have asked, and you have asked this question, Mr. Chairman: how many drug users will we have if we legalize?

Do you know what the truth is?

Chairman RANGEL. No.

Professor WISOTSKY. No one knows. And rather than speculate——

Chairman RANGEL. They know it would be more, though; right?

Professor WISOTSKY. A commission could find out.

Chairman RANGEL. No, no. But you know there will be more?

Professor WISOTSKY. I don't concede that point.

Chairman RANGEL. You are the only one that I have asked the question, and I don't want to get involved because other people say that that is a part of the risk.

Professor WISOTSKY. Well, they may say that. My response is how——

Chairman RANGEL. They don't know.

Professor WISOTSKY. How do they know? What is their evidence?

Chairman RANGEL. Okay. Well, go on.

Professor WISOTSKY. And I will give you three techniques by which you may find out.

Congressman SCHEUER. You asked me, Mr. Chairman, and I don't know.

Chairman RANGEL. Well, so what else is new?

Congressman SCHEUER. Well, you said you didn't know of anybody you had asked who didn't say it was going up.

Chairman RANGEL. What was the answer?

Congressman SCHEUER. You asked me, and I don't know. And I think that is the kind of information we ought to get at subsequent hearings where the testimony will be as excellent and as superb and as helpful as has been the testimony today.

Chairman RANGEL. Well, let me assure you that we will have these hearings just as long as people think that they have some answers.

I want to thank the good doctor here from Berkeley because we will have some dialogue afterward. Don't you worry about these hearings stopping.

Professor WISOTSKY. So if I may continue, there are at least three techniques by which we could make some assessment, and it wouldn't be conclusive, I concede, but some reasonable assessment of what would happen to the incidence and prevalence of drug use.

First, use market research, the good old-fashioned American businesslike approach. Ask the prospective consumer, "What will you do under certain conditions of legality, price, quality, availability, and so forth?" Is it the threat of the law that now stops you from using drugs.

Second——

Chairman RANGEL. Are you talking about running a poll with junkies?

Professor WISOTSKY. I'm talking about running a poll with the American people. I'm talking about focus groups of the kind that were used to design the Taurus and the Sable by Ford Motor Company, in one of the most successful marketing ventures in history. The goal, of course, is the opposite of marketing—to find out how to discourage use without the threat of arrest.

Chairman RANGEL. Okay.

Professor **Wisotsky.** I'm talking about experiments with prison volunteers who are serving life sentences without parole. I am talking about longitudinal studies where you track drug users in the real world to see what the actual experience is, of the kind pioneered with cocaine by Dr. Ronald Siegel of U.C.L.A.

He found, by the way, quite a bit of ground to question the proposition that cocaine is addictive for the population as a whole. This is respectable scientific evidence to cast doubt on the proposition that cocaine is addictive, and a national study commission should be directed to develop further information along those lines.

The fourth point: focus on the big picture. I couldn't agree more with Congressman Scheuer that it doesn't make any difference in the quality of life in America, in our streets, that the D.E.A., the F.B.I., and the Customs Service seized 100,000 pounds of cocaine in 1986, or that they have doubled the number of arrests from 6,000 to 12,000, or that Carlos Lehder Rivas, the "Henry Ford of the cocaine business," according to Robert Merkel, who prosecuted him, is now serving life in prison plus 135 years.

What difference has it made? Where is the emphasis on the bottom line? That is what we need from this Commission, a reasoned, comprehensive, businesslike, professional approach to evaluating new drug initiatives. Meaningless bureaucratic "victories" should be abjured; the standard must be whether there is an overall improvement.

May I also suggest very briefly the four priorities of drug control? And I will just list them because of the shortness of time. The first one should be to protect the children. I wouldn't worry so much about what 35-year-old plumbers or postal workers or investment bankers may be doing. Protect the children. Shift resources away from worthless interdiction programs to protection of children, especially in the schools.

Second, public health and order. This refers to the highways and the work places, and I think drug testing can help a lot in that respect. The public order goal would prohibit drug use in inappropriate places. Public health, on that goal I will defer to experts, but laws should be adjusted to have some realistic bases in actual harms caused.

Finally, a truly constructive program of national drug policy must have respect for the individual, individual liberty, individual privacy.

The loss of the moral high ground in all of this has been that the war on drugs—you are correct, Mr. Chairman, it is not a war on drugs. Drugs are inanimate objects. We have a war on the American people.

We have preventive detention. We have long mandatory sentencing. We have roadblocks. We have airport profiles. We have dog-sniffing. We have one and a half million names in the N.A.D.D.I.S. computer data bank.

We have the good-faith exception to the exclusionary rule. We have, perhaps coming down the pike, the death penalty. We have an assault on the Constitution, as I heard one distinguished Congressman stating to the "New York Times" only a few days ago.

This is the inevitable price of a zero-tolerance policy. This is not consistent with the American tradition of respect for autonomy. The moral high ground here is not to be for drugs or against drugs.

It is for the right of responsible, competent adults to have freedom of choice, to be responsible, to be accountable, to be punished if they do wrong, if they hurt another person, but not to be stigmatized or punished or have the content of their blood or their urine examined if there is no consequence to any other person.

That is the moral high ground in drug control, and that is a priority that I would give to any national commission that was considering a new drug policy for this country.

Thank you. I would finally note that I have submitted a prepared statement for inclusion in the record and an executive summary for the convenience of staff.

Chairman Rangel. Thank you. Without objection, that will be entered into the record.

[Statement of Professor Wisotsky appears on p. 409.]

Chairman Rangel. I was talking to some of my colleagues while you were talking and the Committee is going to poll to see whether or not the panel might consider having a conference without the cameras and without reporters. One of the things that is abundantly clear is that if you take away the concept of legalization and decriminalization, I don't think there is anybody that is in disagreement on this panel, that America just has to do more in prevention and education and trying to help people to help themselves.

There is a serious emotional disagreement with those who seem to be speedily going into the area of making drugs available. As long as you slow down the rhetoric in that area and stay with me in trying to see what are we doing now—and I say this as a preface to introduce our next panelist—in giving access to people that are trying to say "No," and yet they don't have treatment available.

Dr. Mitchell Rosenthal, from New York Phoenix House, has done research, has done work. And with all due respect, he has done it with the people that we are talking about. And he has done it over a number of years. And he has reached out and he has won some; he has lost some. But he certainly is somebody who has never run away from the problem.

And I'm very interested, because more than even I, he spent more time with those that God seemed to walk past, those without hope, those that had given up, those that have no place to stay.

And I thank you, once again, for sharing your views with the Select Committee.

TESTIMONY OF MITCHELL ROSENTHAL, M.D., PRESIDENT, PHOENIX HOUSE, NY

Dr. Rosenthal. Thank you, Chairman Rangel. Thank you very much.

My name is Mitchell Rosenthal. I am a psychiatrist and President of Phoenix House. I have been involved in the treatment of drug abuse for nearly 25 years.

To me, the prospect of legalization is utterly terrifying. It would cause an extraordinary increase in both drug use and in all the destabilizing influences that now threaten our society.

What makes this inevitable are the addictiveness of illicit drugs and their impact on the character, values, and the behavior of abusers. While it may be true that just as many smokers as cocaine users will become, to some degree, dependent, the tobacco/cocaine parallel obscures the sheer power of cocaine addiction, and it ignores the amounts of cocaine addicts would use if access were easy and costs were negligible.

Experimental animals will literally kill themselves, starve to death, take shocks for a chance of getting more cocaine. And cocaine abusers in treatment almost uniformly report that cost alone limited the amounts that they used.

Drug abusers are otherwise not normal folk who happen to use illicit drugs. Drug abuse rapidly diminishes the ability to function normally, to hold a job, to keep up with school work, or to sustain responsible social, sexual, or family relationships.

Drug abusers are driven, self-destructive, and out of control. Abuse lowers self-esteem, erodes character, and prompts behavior that is anti-social, often violent, frequently criminal, and manifests in almost absolute indifference to the impact on others.

Recognizing these aspects of drug abuse, we should take seriously projections of post-legalization drug use that estimate a doubling or even tripling of users when we increase availability and eliminate disincentives.

And we should anticipate the greatest increase to occur among adolescents 12 to 21 years old. Where else are new drug abusers going to be found?

Do not imagine that government regulation of distribution will in any way inhibit access of adolescents. It doesn't now. And there will also be proportionate increases in use among other vulnerable populations, among the unemployed, the homeless, the mentally ill, and the emotionally fragile.

What will be the costs and consequences of these increases? The health consequences will be enormous. Forget the 4,000 fatalities figure that legalization proponents bandy about. We have no idea of total drug-related deaths. But I find Dr. Ian Macdonald's projection of 100,000 drug deaths annually after legalization a reasonable one, and perhaps Dr. Robert DuPont's half a million estimate may be even closer to the mark.

And we can hardly discount the health risk that drug abusers create for nonusers. Plainly, the transmission of A.I.D.S., as Admiral Watkins has testified, is the most serious dimension of this problem.

But health consequences pale before the social consequences of legalization when two to three times as many people will become dysfunctional, when they cannot work or learn, when they cannot be responsible husbands, wives, or parents, when they lose self-regard, when they become socially irresponsible, self-destructive, paranoid, violent, or criminal.

We already see enormous increases in drug-related social disorder, in homelessness, mental illness, disrupted families, family violence, runaways, and child abuse, and neglect.

In New York City, infant mortality involving maternal drug use has doubled since 1983. And drug-abusing parents are now responsible for three out of every four cases of reported child abuse that leads to death.

Increased use will increase crime because drug abusers are irresponsible, self-destructive, and anti-social people, not all of them perhaps, but too many. They go out of control, give way to violence. They do not rob and steal and mug only to buy drugs. And they will not stop robbing, stealing, and mugging, when they get drugs at bargain prices.

To the extent that legalization increases drug use, it will increase crime, and all kinds of crime.

Clearly, the costs and consequences of legalization would be unbearable. They would destroy communities that are now barely able to withstand present levels of disorder and crime, and it would irreparably damage American's society.

Why, then, in God's name, are we even discussing legalization, when Americans today better understand drug abuse and are more committed to confronting it than ever before?

I do not accept the notion that legalization must be considered because interdiction has failed. Law enforcement officials admit that a supply side strategy will not work without reduction in demand. And reduction in demand can be achieved only by a balanced response that involves enforcement, prevention, and treatment.

Let me point out here that treatment is the only response to drug abuse that we know will work. We can and do cure drug abuse. And this capability is what makes a demand side strategy possible, because it will allow millions of men, women, and children to overcome dependency and change the attitudes and values that accompany addiction.

But we cannot cure drug abusers who are not in treatment. And what brings them in are disincentives. That is why enforcement at the street level is so important. That is why the current climate in the country, growing public intolerance for drug use and strong employer drug policies, makes victory over drugs a realistic expectation.

I have been fighting drug abuse for almost all of my professional life, and I would ask this panel in considering legalization or any alternate strategy to focus on the core problem, not to be sidetracked by other concerns, no matter how compelling. And by this I mean that we cannot devise answers to crime or to A.I.D.S. or to any problem that derives, in whole or in part, from drug abuse without attacking drug abuse itself and the conditions that sustain it.

Thank you, Mr. Chairman.

Chairman **Rangel.** Well said, Doctor, well said.

I think the last panelist is Dr. Ethan Nadelmann, Assistant Professor at Princeton University. Good to see you again, Doctor.

TESTIMONY BY ETHAN NADELMANN, PH.D., ASSISTANT PROFESSOR, PRINCETON UNIVERSITY

Dr. **Nadelmann.** It is good to see you, Congressman Rangel. Thank you very much.

I should say I am speaking to some extent in an effort to create concluding remarks for my colleagues to my right. I must say that when we came in here this morning, it was something like the sensation of a visiting ball team going into Yankee Stadium to play the New York Yankees, and the first batter goes up to bat and he turns around and looks at the umpire, and for some reason, the umpire bears an uncanny resemblance to George Steinbrenner. Then he looks down to first base, and the same thing is true, and second base, and third base as well.

I appreciate the presence of some Congressmen on this panel who are willing to listen and to really listen to what we have to say. But at the same time, I feel I must congratulate and thank Congressman Rangel, to thank him for holding what has been a good hearing today, to thank him and congratulate him for his efforts to do more in funding drug treatment and drug prevention, for his efforts to get more funding directed toward dealing with A.I.D.S., and even for his efforts a few weeks ago to stand up against some of the more ridiculous provisions that were introduced onto the House drug bill, ones that really did dig away at the Constitution.

So thank you very much for that, Congressman Rangel.

Now, let me say first that nobody on this panel sees legalization, decriminalization as a surrender. We wonder, in fact, if it was a surrender, why is it the policy that the drug dealers fear most?

Let me say something else, that all of us on this panel here are parents. In fact, Congressman Rangel, since we last saw one another two weeks ago, I became a parent. Just ten days ago, my baby daughter Lila was born.

Chairman RANGEL. Congratulations.

Dr. NADELMANN. Thank you very much.

None of us would be advocating the policies we do if we thought that it would lead to a worse world for our children or for other people's children as well.

Chairman RANGEL. It depends on where you live, Professor.

Dr. NADELMANN. No. It's more than that, Congressman Rangel. In fact, our analysis is based upon a great deal of empathy for other people's children as well.

Chairman RANGEL. Let's not bring the children in, because it gets a little emotional. Congratulations. You are a new father.

Dr. NADELMANN. Thank you.

Chairman RANGEL. And we are trying to keep emotions out of it. We all want to leave a better world than the one that was left to us. That is a fact.

Congressman SCHEUER. And mazel tov.

Dr. NADELMANN. Thank you, Congressman.

Now, you have asked, "What is legalization?" What do we mean by "legalization"? Let me suggest to you that legalization is really two things, and it has to be separated. We have to understand it.

First of all, legalization is a model of analysis. A synonym might be a cost benefit analysis of current policies. It is a way of looking at the drug problem that says we have to look at current policies, analyze what are their costs, what are their benefits, and compare those with other policies, including different models of legalization. That is what it is about.

Now, people talk today about the drug problem, the "drug problem." What do they mean by the "drug problem"? Imagine having people talk about the "economy problem.": "What do you mean by the "economy problem"? Oh, well, I mean, inflation, unemployment, the trade deficit, the budget deficit, declining productivity. We have got to do something about the economy problem."

Well, we are not going to get anywhere in dealing with the drug problem unless we sort out what we mean by it. Now, during the 1920s, people didn't talk about the "alcohol problem." They made a distinction. They looked, on the one hand, and they saw that there was an alcohol problem, a problem with alcoholism and alcohol abuse.

But then they looked at everything else. They looked at Al Capone and organized crime and rising corruption and tens of millions of Americans fighting a law and even people dying of bad bootleg liquor.

And they said that is not part of the alcohol problem. That is part of the prohibition problem. And they said in the end, even if prohibition works, to some extent, in reducing the extent of alcohol abuse, it is simply not worth it, not worth it on a societal basis, not worth it on a cost benefit basis.

Today people talk about the "drug problem," and no such distinction is made. We do have a drug problem. We have a problem of drug abuse and drug addiction. No question about it.

And it is a serious problem in this country, not as bad a problem as the cigarette problem or the alcohol problem, the abuse of those substances, but, nonetheless, a serious problem.

But then let's look at everything else. Let's look at what is happening in our cities. Let's look at the rising corruption, the overflowing prisons, the people dying of bad drugs, what is happening with friendly governments around the world.

All of those things, that is not just part of the "drug problem." That is the consequences of the drug prohibition laws.

I think it is important to make that distinction. I think there is no way that any of us or that this country is going to move forward on this policy until it makes that distinction and begins to pursue a policy based upon understanding that.

Now, it is not really true to say that we haven't yet begun to fight a war, if that is what you want to call it. It's not really important that only 3,000 Federal drug agents are involved in this.

When you look at the fact that Federal law enforcement expenditures devoted to drugs have gone from one billion to three billion. In the United States, traditionally, law enforcement is handed over to local and state government. That is a firm tradition in this country.

Almost 20 percent of all local and State law enforcement resources are devoted to dealing with drugs. In Washington, D.C., over 50 percent of all the people in the jails here are there on drug possession or drug-dealing charges. In New York, it is over 40 percent.

In the Federal prisons, over one-third of all the inmates are there on drug charges—not on "drug-related" charges but on drug-dealing charges. The U.S. Sentencing Commission estimates that

that will go up to 50 percent of a population of 100 to 150 thousand in the next 10 to 15 years. Those are tremendous costs.

Three-quarter of a million Americans arrested each year on drug charges, mostly marijuana charges, is a tremendous cost. It is not just the dollars; it is the diversion of law enforcement resources, from going after the more important types of criminals, the types of criminals that people cannot walk away from.

Now, Congressman, I know you are eager to hear me get to the second part.

Chairman RANGEL. Well, I wish I could.

Dr. NADELMANN. Well, Congressman, if you would just extend me the same sort of five-minute rule that you've extended to many of the other spokesmen on the other side today, I'd greatly appreciate it.

Chairman RANGEL. As I indicated, we're going to try to wrap up this panel and I wish we wouldn't hear the display of emotion from the audience. I'm more than certain that on the questions, I will ask you the first question.

And that question would be, "What do you think about legalization?" That's why we had the hearing and I'll ask you in my first question, as the Chairman, as to what are your views on legalization. Fair enough?

[Statement of Dr. Nadelmann appears on p. 457.]

Chairman RANGEL. Okay. Let's hear from the last panelist, Sue Rusche from the National Drug Information Center, Families in Action.

TESTIMONY OF SUE RUSCHE, NATIONAL DRUG INFORMATION CENTER, FAMILIES IN ACTION

Ms. RUSCHE. Thank you very much, Mr. Chairman, for having me here. I want to thank you for your leadership on this issue, and I want to thank you for having somebody here who is representing families, because families have been left out of this debate, and we're angry about that.

We have a lot of insights to share with you in the efforts that we have made over the last 12 years to prevent drug abuse in our families and in our communities. And we have a lot of insights to share with our friends who would propose that we legalize drugs as a solution.

Legalization proponents keep asking us to use and look at the cigarette and the alcohol model. Let's do it. Last year, the cigarette and alcohol industries spent more money to advertise their products to Americans than Congress appropriated to fight drugs. I don't think that we want any more legal industries amassing those kinds of profits with which to sell their products to our children and to ourselves.

Another argument that proponents give us is that "alcohol is legal but we don't sell it to young people." Malarkey. Few realize in this country how easily youngsters and sometimes very young youngsters buy alcohol.

Alcohol sales to minors occur routinely as sales clerks either fail to ask for identification to verify age, or look the other way when obviously underage young people present fake I.D.s as proof they are 21 when they are actually 14 or 15.

Moreover, like the tobacco industry, the alcohol industry spends $1.4 billion, which targets children and teenagers. The large number of beer commercials that feature rock stars and that appear on stations listened to exclusively by children is one example.

Another is the Spuds MacKenzie dogs T-shirts in kid sizes. A third example is wine coolers on grocery store shelves which are shelved between bottled waters and soft drinks.

It's no wonder with this kind of merchandising effort of these two legal drugs of ours, that 79 percent of fourth, fifth and sixth graders don't know wine coolers contain alcohol. Or that 8- to-12-year-old children in our country can recognize and spell correctly more brands of beer than U.S. presidents.

If we cannot prevent an alcohol industry and a tobacco industry from selling to young people, over the counter and over the air waves, how can we expect to prevent an opiate industry or a cocaine industry from doing the same?

A third argument that proponents make is that we live with cigarettes and alcohol; we can live with drugs, implying that illegal drugs are less harmful than alcohol and tobacco.

In reality, illegal drugs are at least as harmful, if not more harmful, than alcohol and tobacco. Illegal drugs kill fewer people, only because fewer people use them. Keeping them illegal holds use down. Eighteen million marijuana users compared to 116 million alcohol users. Six million cocaine users compared to 60 million tobacco users.

The greatest single difference between legal and illegal drugs is that illegal drugs generate no profits to spend on advertising and marketing. Once a democratic society legalizes drugs, the forces of free trade and free speech will take over and drugs will be mass marketed as alcohol and tobacco are mass-marketed today.

Finally, proponents tell us that we should look at alcohol and tobacco as a model, but no one has made the point that alcohol is the leading cause of death, I repeat, the leading cause of death, among young people in this country. In addition, alcohol kills a total of a hundred thousand people each year, as has been noted, while tobacco kills between 350,000 and 500,000 more.

We throw those numbers around, but I wonder how many people can really perceive what those numbers mean. Not many blocks from here stands a wall which records the number of Americans killed in Vietnam over a 10-year period. It would take two Vietnamese walls each year to record the names of people killed by alcohol, and another 7 to 10 walls each year to list those killed by tobacco.

The family-based prevention movement has been trying to get the nation to see that we don't live with alcohol and tobacco; we die with it, in numbers that we are emphatically no longer willing to tolerate. Can anyone honestly suggest that the families of this nation would be willing to tolerate the additional deaths legal cocaine, crack, heroin, et cetera would bring, should we legalize those drugs?

A fourth argument proponents make is that taxes from legalized drugs could be used for education and treatment. That sounds like a great idea. Let's look at our alcohol and tobacco model and see how many alcohol and tobacco tax revenues, in fact, are being used for education and treatment.

The answer is zero. In fact, the profits from these industries are so great and the lobbying that those profits buy is so great Congress hasn't increased alcohol or tobacco taxes since 1951.

Legalization will take the profits out of drugs, proponents say. That too is malarkey. What drives prices down is increased supply, which occurs as the result of mass production.

What keeps prices down is increased demand, which occurs as the result of mass marketing. When both supply and demand increase, profits go up and not down.

Legalization won't eliminate profits. It will simply shift them out of the pockets of traffickers and into the hands of legitimate businesses. Drugs will be driven off the streets of America—straight into the shops and stores of America.

Do we really want this? I think not.

Other points legalization proponents make include: We have always been a drug-using society. This is simply not true. As recently as 1962, less than 2 percent of the entire population of this country had any experience with any illicit drugs, according to Dr. Schuster and N.I.D.A.'s 1979 Household Survey.

Proponents also say decriminalization won't increase use. Again, malarkey. Proponents ignore the fact that we have a model to look.

Between 1972 and 1978, eleven States in this country decriminalized marijuana. As a consequence, during that time marijuana use rose 125 percent among young adults, 130 percent among high school seniors, 200 percent among older adults, and 240 percent among teenagers.

Proponents also claim drug abuse is now worse than it's ever been. That, too, is not true. As Dr. Schuster and others have noted, we are beginning to see drug abuse in this country level off and, in some cases, decline.

The two most dramatic examples are marijuana use among high school seniors, which has been driven down from 11 percent to 3 percent, and a drop in cocaine of one-third in one year. What has gone up in both cases is knowledge about harmful effects, from 35 to 74 percent in the case of marijuana and from 34 percent to 48 percent in the case of cocaine.

Does this mean we don't have a drug crisis? No. It means we have a drug solution, if only we will pay attention to it. For more than a decade, family-based prevention groups have been driving drug abuse down.

We would like to see Congress build on these gains, institutionalize the prevention movement, and empower families by creating a National Drug Corps, similar to the Peace Corps, that would employ mothers and fathers and children for a period of time to be trained with the drug-prevention techniques developed by family-based prevention groups for the last 10 years, and then sent back home to drive drugs out of their families and out of their communities.

Thank you very much, Mr. Chairman.

[Statement of Ms. Rusche appears on p. 471.]

Chairman **Rangel**. Thank you. And the panel should know that their entire statements will be entered into the record. I am taking this opportunity to ask staff to prepare a packet of the testimony we receive today and make it available to all of the panelists.

And I do hope that, at least as it relates to those who are dealing directly with the drug abuse problem, that we might arrange some day to get together and share some ideas.

Now, Doctor Mikuriya indicated that on a recent television program, I asked a series of questions and he was really very anxious, even though he wasn't part of that panel, to answer them. And I'm going to study your responses and work very closely with you, Doctor. But from the person I was asking all of those questions, I found it very, very difficult, at least on television, to get an answer. And that was Doctor Nadelmann. And——

Dr. **Nadelmann**. Well, Congressman, I found it very difficult to get a word in edgewise, actually.

Chairman **Rangel**. Well, you're going to have more than enough time to get your words in today.

Dr. **Nadelmann**. Thank you very much.

Chairman **Rangel**. Now, in a recent article you published, you indicated that the minority communities in the ghetto, for whom repeal of the drug law promises the greatest benefits, fail to realize the costs of the drug prohibition policy for what they are.

Now, if you recall, I asked you a series of questions, and I think the moderator of the program did, too. And that is, have you decided what drugs you will legalize?

What was the basis of excluding other drugs, because we know that addicts would want to get whatever they can get?

How much would you legally give a drug addict, whether or not the doctor would determine the amount that would be the legal dosage.

I asked whether or not you had any facts or experience to determine whether addicts, after they receive their so-called "legal dose"—and that's why I want to deal with the psychiatrist from Berkeley, who has dealt with Methadone, and I unfortunately, have too—whether they would go into the illicit market to get what they think was necessary for them?

I was concerned as to whether you were going to exclude children and whether or not the availability of more drugs, legal drugs, would encourage children to go to the illicit markets so that they would become, quote, "eligible" in order to get the so-called legal drugs.

I was concerned as to who would dispense it. Whether it would be the local doctor, whether it would be the pharmacist, whether it would be a clinic, whether it would be a public health service.

I was concerned as to whether or not this would be financed through national health insurance, whether we would have to mandate that older people, who were addicted to drugs, or wanted to get drugs, or whatever criteria you use there, whether you would include that in the health package? Whether or not we would exclude the poor, but since you mentioned minorities, I assume that in this area they would not be excluded.

Would they come under Medicaid? Would there be drug stamps for them?

Would we in this great society, since we don't grow opium and we don't grow coca leaves, really be exporting all of this from the very same countries that we have agreements with saying that it's illegal to grow?

Would we break those treaties, agreements, and tell our farmers that there's new life for them from bankruptcy, that we're going to grow our own coca leaves, our own opium? And would we start our own processing?

And for those who talk about taking the profit out of drugs, I guess you mean taking it from the street hoodlums and putting it in the multinational corporations, the pharmaceuticals?

Now, I know when you're writing books, that sometimes these things don't really make that much difference because basically what you're saying is, I'm not advocating this, I'm saying it should be discussed. But I didn't see anywhere in your testimony even a meager attempt to deal with some of those serious questions.

And I might add that Doctor Mikuriya came forward at least and said he's going to wrestle with it, and at least he's going to try to consider regulations and restrictions.

I think this hearing so far has been a tremendous success because all of the, quote, "advocates" want to debate. I don't know who they want to debate with.

Dr. NADELMANN. Well, Congressman, could I respond to that?

Chairman RANGEL. I wish you would.

Dr. NADELMANN. First, let me ask if I may have entered into the record both the two articles that I've written in the journals Foreign Policy and the Public Interest, and also have entered into the record two articles that appeared in the most recent editions of Reasons magazine, one of which is based on interviews with law enforcement officials who support legalization but who are not represented here today, and secondly, to have entered in an article that has what eight or nine people who do support legalization see as what it would look like, what would be gained from it, and what questions we should be asking.

Chairman RANGEL. I'd like to make it clear——

Dr. NADELMANN. Now, what you're asking for, Congressman——

Chairman RANGEL [continuing]. That nobody has requested to testify, nor has anyone been recommended by Mayor Schmoke, that has been refused the opportunity——

Dr. NADELMANN. Congressman, both——

Chairman RANGEL [continuing]. So the way you stated it——

Dr. NADELMANN [continuing]. Both Mayor Schmoke and I have received numerous communications from law enforcement officials, from political figures, from judges, and many others who agree with us and who feel that they are not in a position to go public with their support. There are, however——

Chairman RANGEL. Okay.

Dr. NADELMANN [continuing]. Some, and it would be useful to have their information——

Chairman RANGEL. I just wanted to make the record clear——

Dr. NADELMANN. Now, Congressman, you're asking me——

Chairman RANGEL [continuing]. That it was open.

Dr. **Nadelmann** [continuing]. For a checklist of what this whole thing would look like. That's really in many ways an absurd idea. It's certain that when people created the current criminalization policy, they didn't set up a checklist. They didn't even undertake any form of analysis.

What I am suggesting when I talk about legalization is that we go step by step, analyzing the costs and benefits of each measure we take. Now, what I began to say on the Ted Koppel show two weeks ago and I'll say today is that the first, the first step is this: I think the House can throw away the bill it came up with two weeks ago and support a bill as close to the bill, the Moynihan-Nunn Bill in the Senate, as possible without amendments.

And that's a bill that is relatively high on drug treatment and education and relatively low on wasted enforcement funds. I think that's a first step.

Chairman **Rangel**. Doctor, we're just talking about——

Dr. **Nadelmann**. I think a second step is thinking about——

Chairman **Rangel** [continuing]. Legalization.

Dr. **Nadelmann**. Congressman, I'm going all the way. I'm going all the way and I'll lay it all——

Chairman **Rangel**. I know, but you're starting from Genesis. We're talking about legalization and decriminalization. Could you kind of go back——

Dr. **Nadelmann**. Congressman, you don't begin an analysis by starting with Deuteronomy. You start from the beginning and that's what we're trying to do today. Okay.

The second step is the step that Mayor Schmoke and Professor Trebach spoke about—the medical availability of marijuana. A number of years ago, about 80 Congressmen sponsored a bill to make marijuana medically available. You, yourself, sponsored that bill almost exactly six years ago. That's the type of measure that should be supported.

A number of years ago, the medical availability of heroin was sponsored by Senators Inouye, DeConcini, Hatfield, Symms, Hollings, and 11 others. That's the way to go.

In fact, in this body a number of years ago, the decriminalization—Congressman, believe me, I'll tell you this—the decriminalization of marijuana was advocated by many members of the House and by the Senate.

I think the legalization of marijuana is a good step. It accounts for over half of all of the three-quarter million arrests each year. It accounts for a large degree of what the interdicters in this nation do.

Sixty million Americans have smoked marijuana. Between 20 and 30 million Americans smoke it today. And we have not one overdose death.

I agree with the panelists that those people who drive or fly planes under the influence of marijuana or any other substances should be thrown in jail——

Chairman **Rangel**. Admiral Watkins——

Dr. **Nadelmann**. But I do think that——

Chairman **Rangel**. Thank you. Admiral Watkins has to leave and I want to take a break here. And thank you so much for being with us. And if you think, Doctor Nadelmann, that you've answered any of the questions——

Dr. **NADELMANN.** I'm just beginning, Congressman, I'm just beginning.

Chairman **RANGEL.** I know you are, but unfortunately——

Dr. **NADELMANN.** And as you may know, a good analysis——

Chairman **RANGEL** [continuing]. Time doesn't allow——

Dr. **NADELMANN** [continuing]. Requires a few minutes for delivery.

Chairman **RANGEL** [continuing]. My questions. I had some questions that your colleague from Berkeley had no problem in attempting to answer, but the same thing that happened on the program is that you're attempting to do it here, and maybe I will submit my questions to you in writing.

Dr. **NADELMANN.** Congressman, the same thing happened on the Ted Koppel program——

Chairman **RANGEL.** You might be kind enough to——

Dr. **NADELMANN** [continuing]. Because by the time I get done with Genesis, you want to cut me off. I'm willing to go through the next——

Chairman **RANGEL.** That's okay.

Dr. **NADELMANN** [continuing]. Chapters of this if you're willing to listen——

Chairman **RANGEL.** No, no.

Dr. **NADELMANN.** I think it is important——

Chairman **RANGEL.** I think that——

Dr. **NADELMANN** [continuing]. That in this things could be said——

Chairman **RANGEL.** I know.

Dr. **NADELMANN** [continuing]. And could be presented——

Chairman **RANGEL.** I know. I will——

Dr. **NADELMANN** [continuing]. To the public——

Chairman **RANGEL.** I will ask you to submit the responses, if I ever get them, in writing and——

Dr. **NADELMANN.** Congressman, you can have them right now, if you like.

Chairman **RANGEL.** Is anyone else——

Dr. **NADELMANN.** It might be productive.

Chairman **RANGEL** [continuing]. Seeking recognition?

Congressman **SCHEUER.** Yes. Can I ask questions, or are we winding this down?

Chairman **RANGEL.** You're here to ask questions; we are winding it down.

Congressman **SCHEUER.** All right. How much time do I have, Congressman?

Chairman **RANGEL.** We have a five-minutes that we'll hear and——

Congressman **SCHEUER.** Very good. First of all, Congressman, I want to congratulate you in retrospect. After having sat through a whole day of hearing, these have been enormously stimulating.

And you're due great credit in having organized them. I hope that as we continue through this day of hearings and the second day of hearings, and the subsequent hearings of some kind, which you've indicated are in the cards, will sort of relax this rigid preoccupation with those two words that I don't want to mention, the "D" word and the "L" word, and expand the scope of our inquiry, which I think ought to be, "What are the alternatives to a present failed system?" "How can we improve it?"

By any guise, by any new approach, not an exclusive preoccupation with the legalization or decriminalization. What are the options out there for a painfully, pathetic failed system? This ought to be our approach.

And I really want to congratulate you for having this hearing and for the subsequent, whether they're hearings or conferences or seminars, it's terribly valuable.

We've got marvelous witnesses out there. There are other witnesses that we can have. And I think this is an extremely useful process. I'm glad that it's the beginning and not the end.

Now, I'm going to ask the panel two questions. And I want to say what a privilege it is to see the Admiral here. He's a great American. He's done yeoman service in so many areas. He's made a remarkable contribution.

I have two questions, for whatever time I have left. And I'm going to ask any members of the panel who would want to respond. First of all, I've heard several references here today to whether it's providing needles or decriminalization, legalization. We're sending the people a wrong signal. Now, I have real doubts about that.

The kids of America know damned well that we don't want them to go on alcohol, we don't want them to go on tobacco, we want them to stay off of barbiturates, hallucinogens, amphetamines. These are legal drugs, but we want them to stay off it.

Shouldn't it be possible to eliminate this, what I consider a dubious argument about sending people the wrong signal, especially since one of the great things about the possibility of either legalization or decriminalization or a host of other approaches, including free needles, is that we get people to surface.

We can identify them. We can put our arms around them. There they are here, not in some back alley, not in some subterranean whatever, we can identify them and communicate with them.

And we can send them the right signal when we get our hands on them. That's one question I'd like to ask. The other question I want to ask is the following. I think we all agree that we have to have a much better focus on prevention, on education, than we've had up to now.

Drugs is the greatest killer of education dreams in our country. Yet we spend less than one percent of the Federal Education budget in drug education. We can all agree that we can do much more in prevention, much more in treatment, much more in education.

Is there any other systematic institutional change we ought to have in our system other than this diversion of far more resources into education prevention and treatment? Is there any institutional structural change that we ought to make in our system that would make it more rational, more cost-effective and would meet the goal, not of increasing arrests, not of increasing seizures of equipment, but of actually stanching the flow, the hemorrhage of drugs into our neighborhoods and into the arms of our kids. Those are my two questions.

Dr. **Trebach**. Could I respond to the first?

Congressman **Scheuer**. Yes. Please.

Dr. **Trebach**. On the first one, I feel very strongly that people understand that, certainly, my advocacy of legal change, and I think all of the members of the panel's advocacy, would recommend that we accompany that legal change with an enormous emphasis on building up communities and building up families.

There's nothing inconsistent with many of the points that were raised on the other side. I applaud the parent's movement. I applaud the idea of control.

I remember when I was once addressing a group of parents in the American University chapel. Many of them got uncomfortable with my position as did some members of this panel. At the end of it, a woman walked up to me, a parent, and said, "All I can say, Professor, is more power to you. I am a police officer in western Massachusetts and the parents in my town come to me and say, 'You've got to keep my kids off drugs.'

"And I reply to them, 'I'll keep my own kids off drugs. I'll pull other kids out of wrecks when they get in trouble, or I'll do some things where they are very obvious, but it's up to every parent to deal with their own kids regarding drugs.' "

And what we are saying is, police are inappropriate to help our children stay off drugs. So, clearly, if we make a change in the law, it must be accompanied by massive education, supportive parent's groups——

Congressman **Scheuer**. Counseling.

Dr. **Trebach** [continuing]. Counseling. But build up all of the cultural institutions that have failed us. The reason people take drugs today are very complex. But one of the most important is that the families and the communities have broken down and we must pay attention to all the values that support families and communities. That is not a good job for the police.

Ms. **Rusche**. May I respond? I would like to add something, or a different viewpoint perhaps. The mythology is that children use drugs and older teenagers use drugs because families have failed.

The reality is that this kind of drug use has been going on in many respects because we have been selling drugs to kids, through head shops that parents and families fought to put under, to make illegal, to get rid of 10 years ago.

In the absence, the stopping of de-crim, which was giving kids that very message, that if the government is willing to decriminalize marijuana, there really can't be very much wrong with it, the stopping of de-crim and the substitution of responsible use messages with no use messages are the three ingredients that began turning drug abuse around and driving it down. Thank you.

Mr. Chairman, I know time is very short, but it seems like it took all day long to get to the point of families and I'm very concerned about the breakdown of the family structure in our society. Government has played a role in that. There are things we could do within our social structure to perhaps bring families together. Our whole Welfare Act has gotten the man out of the house before welfare would be granted. That's wrong.

There are social policies that have been counterproductive. We do very little to give jobs to teenagers. Forty percent, 50 percent of the minority groups teenagers have very little hope, great deal of despair and don't have a job to look forward to.

So there's many things that we can do and bringing together the families and families are changing. We have more single parent families than we ever had before. And they take the children and put them into day-care centers. There's less parental supervision.

And the grandmother and grandfather that used to be in the home aren't there any more. They're in a senior citizen's institution somewhere. Or perhaps there is no longer the family unit as we understood it traditionally.

And I think this breakdown is a very important part of the overall problem. Because you're not going to get to the answers until you get to the deep social problems that lie underneath in our society. Thank you, Mr. Chairman.

Chairman RANGEL. Thank you. Doctor Mikuriya, we may disagree, but certainly we have not been disagreeable. And you have attempted to respond to some of my concerns. Let me ask you, when you say that drugs should be legalized, are you talking about heroin?

Dr. MIKURIYA. Yes, I am. I'm talking about——

Chairman RANGEL. Are you talking about cocaine?

Dr. MIKURIYA. Yes.

Chairman RANGEL. Are you talking about crack?

Dr. MIKURIYA. All controlled substances.

Chairman RANGEL. P.C.P.?

Dr. MIKURIYA. Yes.

Chairman RANGEL. L.S.D.?

Dr. MIKURIYA. Yes.

Chairman RANGEL. Now, there are some people who believe that there is no such thing as satisfying the needs of some people who take these drugs. And that certainly you would not believe that you should give enough to a person to kill themselves, commit suicide, or overdose. At some point the doctor is going to say, "This is, what, your legal quota?"

Dr. MIKURIYA. Well, the way a person would enter this voluntary drug users coop would be to take a test very much like a driver's test, so that would demonstrate knowledge of the effects of the drugs, as well as demonstrating prima facie evidence of the responsibility for complying with the conditions of the program.

Chairman RANGEL. What would the conditions be? I'm talking about just one of your ordinary heroin addicts who really believes this is an opportunity to get pure stuff instead of the stuff he's been dealing with and he wants——

Dr. MIKURIYA. At a much lower price.

Chairman RANGEL. Well, that's another question. But assuming that it's a good deal, I want to know how much you gotta give them at any price.

Dr. MIKURIYA. I really can't give you a specific milligram amount.

Chairman RANGEL. I didn't really mean that. I mean, he doesn't tell the doctor how much.

Dr. MIKURIYA. He doesn't even know how much he's getting when he deals with his dealer.

Chairman **Rangel**. Okay. And if the body's still craving for this drug, whether it's crack, whether it's P.C.P., whether it's cocaine, from what I understand, and from what some of the panelists are saying, unfortunately the chemicals take over the body like an alcoholic with a bottle of liquor. They really can't say what's enough for them.

And it's my understanding that with an addict you have pretty much the same situation. They really can't say what's enough for them. Now, if that is a hypothetical, I think you would have to agree with me that somebody has to say enough is enough, and maybe kick them off the program, but you just can't allow someone to O.D. merely because you're providing it legally.

Dr. **Mikuriya**. Congressman, I agree with that, and there is a provision that specifies in this proposal that if there are signs of dysfunction or abuse of the drug that they would be referred to contracting community resources for treatment. They would be suspended from this program and put on a much more restricted status and encouraged to get treatment.

Chairman **Rangel**. Restricted status? You were in Methadone programs, weren't you? And I'm very close to Methadone programs. They go in, get what they want at the Methadone program. They come in the street and get what they want to supplement it. It's as simple as that.

Dr. **Mikuriya**. Well, it depends on how much they're being given. If they're being given an adequate amount for maintenance, and if there are adequate ancillary features to the program instead of just——

Chairman **Rangel**. That's what I need, some help. You talk about maintenance and people trying to get high. Can an alcoholic be maintained on alcohol?

Dr. **Mikuriya**. Probably not, for people that are alcoholics, because they probably have a different metabolic setup, just the way——

Chairman **Rangel**. Now, the person I'm talking about, Doctor, just for purposes of this exchange, is the addict that, the more they get the more they want, every dollar they get they want more. Now, that's the person I'm talking about.

I'm not talking about giving them enough to get them in a program and weaning them off, and making them straight. I'm talking about legalizing it and dispensing to him based on some doctor and some psychiatrist saying that this person has a need. And you've got to cut it off somewhere.

Then I'm concerned because of the interests of those minorities that don't realize how well off they'll be if we did legalize it. But those that have hope. In other words, those that go to drugs because they don't have anything else, under your suggested solution, would this be a public funded program for the poor?

Dr. **Mikuriya**. It would be a transaction-supported system with the user paying for the cost of the drugs plus a modest overhead for management of the program and treatment.

Chairman **Rangel**. Now you know who I'm talking about if I talk about heroin addicts.

Dr. **Mikuriya**. Okay.

Chairman RANGEL. We're not talking about them paying for anything, right, Doctor?

Dr. MIKURIYA. That's right.

Chairman RANGEL. Now the Federal Government or the local government would pay for it?

Dr. MIKURIYA. The only way I could see government paying for this would be through something like a scholarship for a temporary period. And this would be under review by a drug treatment board which would be set up under the system that I am proposing.

Chairman RANGEL. Now, you know you're dealing with a society that won't give a kid a scholarship that has already graduated from high school and wants to go to college. But you're suggesting that we might be able to persuade our colleagues to give him a scholarship for a narcotic maintenance program.

Dr. MIKURIYA. This is Methadone maintenance. This is the idea behind Methadone maintenance, to find——

Chairman RANGEL. I think it's a terrible idea, but what you're saying is that you should expand the Methadone maintenance program until all other types of drugs are made illegal.

Dr. MIKURIYA. No. I don't think the Methadone maintenance programs, the way they're currently run, are run very well, because of the excessive layers of bureaucratic legislation and making it difficult and expensive for the addicts to get on. Again, we're talking about absence of slots for treatment. In California, I can tell you that 9 out of 10 people cannot get any kind of treatment.

Chairman RANGEL. Doctor, you and I would have no problem if we had exhausted our ability to provide treatment for all those who want it. And even more for those who don't want it, because we're going to try to encourage them to get in it.

If we had treatment, as the Doctor said, for those facing about two years, pardon the expression, in jail, but saying that the alternative would be to go to someplace to get treatment, then I don't even know whether we would even get to where we're talking about this business about maintenance and heroin and scholarships for drugs.

And so I have not exhausted my energy in that other area, and I'm not giving up, and that's it. But you're talking about now, at least some of your panelists, exploring some of the possibilities of legalizing drugs, dispensing it, and then you were saying something about providing a scholarship.

There are no scholarships. You're talking about a Federal subsidy for the person who can't afford it, for drugs. That's not a terrible word, you know. Medicaid.

Dr. MIKURIYA. Be cheaper than what's happening now.

Chairman RANGEL. Well, I don't know. We got Medicaid mills in New York City today. Doctors are selling legal drugs.

Dr. MIKURIYA. Yes, but how many are eligible for treatment for drug problems under Medicaid?

Chairman RANGEL. Oh, my God. You ought to see the rip off under the existing program. I hope you have——

Dr. MIKURIYA. No, we don't have it in California, believe me.

Chairman RANGEL. The next time you come to Washington or New York, you call me. I'm going to walk you through more Medicaid places where doctors are examining only addicts and prescribing for them whatever the prescription would allow. And then the next day . . . Who's from New York State? Listen, the A.M.A. won't do anything about it. The American Pharmaceutical Association won't.

Dr. **Mikuriya**. We do not have that problem in California.

Chairman **Rangel**. Well, It's a national problem, it's not just New York State. But that's with legal drugs. I'm talking now about the expansion of these addictive drugs and making them available.

How would you handle the question, Doctor, of coca leaf and opium? Would we really start exporting it from the very countries that we have international treaties with?

Would we really change it and say that we now develop a legal market, or would you make the Congressmen just super Congressmen by going to the rural areas and telling the farmers, "Have we got good news for you?" and subsidize that?

Dr. **Mikuriya**. Congressman, I feel that these kinds of markets would be taken care of by the legitimate pharmaceutical markets that existed before the driving out of the good money by the bad, as it were.

We didn't have the narco-politics nationwide and internationally with the distortion of economies and disruption of political systems with this artificial market setup.

If the situation reverted to one where the pharmaceutical companies handled it as they did before, we would not have this destabilization politically. We wouldn't have this tremendous upheaval internationally.

Chairman **Rangel**. Well, the way the private sector handles this now, because a lot of people say, "Take the profit out." They mean out of the street, out of the hoodlums, out of where it is prohibited, but they will now be involved in the profit motivation. They would be involved.

Would they be able to encourage different people from different modalities to send Dr. Schultz out and say, "What you really ought to be suggesting is speed instead of crack?" Would they be able to tell Dr. Rosenthal that heroin is still based on what they are manufacturing and again it wouldn't just be for government use?

Government would be for the poor, but now we're going into the general market. Would they be able to send packages to the physicians and say, "If you're treating someone that's down in the dumps and has nowhere to go, try this sample under the free market?"

Dr. **Mikuriya**. I think that this type of merchandising would be limited by, of course, making sure that all of these drugs were included under product liability laws and that any inappropriate advertising would expose these manufacturers to possible settlements for advertising which encouraged adverse reactions. And that same principle of increasing responsibility in the industry should be applied to the alcohol and tobacco people.

Chairman **Rangel**. I want you to have a——

Dr. **Mikuriya**. The same principle of the accountability of the manufacturers for toxic reactions to the substances. And this is what I would see as the counterbalance toward the potential exploitive use of these substances by the pharmaceutical industry——

Chairman **Rangel**. I want you to have lunch with Doctor Rosenthal, and I'm paying. Two people like you can't be that far apart. I mean, really. Doctor Rosenthal will be your lunch partner here.

Dr. **Rosenthal**. Doctor Mikuriya must be treating a group of patients that's very different than the ones that we've seen over 20 years.

Chairman **Rangel**. I'm not leaving you out, Doctor Trebach.

Dr. **Rosenthal**. Because I don't think that the question that you raised before, Mr. Chairman, was hypothetical at all, when you said, "How is it going to be enough?" The fact is, we see patients who have a mild heart attack go into an emergency room because of cocaine use, get some treatment, and 20 minutes later are buying something else.

Or go in with a minor stroke, unconscious, get up off the table, go out, and 15 minutes later are buying more cocaine. There is not enough for most of these patients. And we have created a hypothetical on the other side. We have created an imaginary addict who is going to be rational, thoughtful, appreciative, and is in some way going to really be grateful to us for this new kind of largesse.

The fact is, in England, which has been bandied about here, and we helped the English Government back in 1968 when there were no drug-free treatments in England and their whole policy was based on the fact that they thought addiction was incurable. And what they were doing was giving away doses of heroin to people who were registered.

It was an active black market. And those people went on, just as you were talking before about the numbers of patients in Methadone treatment who will also go on to get something else because they are trying to fix something else in them that hurts. And there is not enough.

It goes on and on and on. There is no end to it. And so all we're doing is feeding a monster instead of saying, "No, there is going to be no more."

And I think this whole suggestion is based on some conceptual, perhaps academic framework. It has nothing to do with the people that you know and that I know are in the streets and in treatment.

Chairman **Rangel**. And the pain that's involved.

Dr. **Mikuriya**. Oh, the trouble is I meet these people all the time, every day, the people that he's talking about and, "Where can we get treatment?"

Chairman **Rangel**. Doctor——

Dr. **Mikuriya**. You know, we would like to get them in treatment. They want to be in treatment——

Chairman **Rangel** [continuing]. You know, no one's arguing with you. Don't you understand that we agree with you a hundred percent on treatment? I don't know how we miss each other. I don't think there's anyone at this table that would disagree that we have let America down when we just say, "Just say 'no.'" And then when they want to say no, that they can't get treatment.

Dr. **Mikuriya**. Yeah. You know I have been involved with this for 21 years and I can tell you that the treatment programs are the last to be funded and the first to be cut. There is no reliable source of funding for continuing——

Chairman **Rangel**. Doctor, if I could have your mind, your energies and your experience to join with us in fighting locally and statewide. I mean, even in our city. We don't even have city rehabilitation. The state does it all. The Federal Government tries to fund them.

It's not right. It's not moral. And I'm telling you that if I had to vote to legalize some drugs for some centers to see how those children are just born addicted to drugs, screaming with withdrawal and know that I played some part in making more drugs available for more people and that it was legalized, I would feel terrible.

But what I am saying, Doctor, is that you don't really think we have to reach that point to talk about the legalization of all drugs. Don't you think we should talk about treatment on demand first?

Dr. **Mikuriya**. As part of a comprehensive package——

Chairman **Rangel**. Are you saying that treatment on demand——

Dr. **Mikuriya** [continuing]. That has to be part of a package.

Chairman **Rangel** [continuing]. Should include all drugs as a modality?

Dr. **Mikuriya**. I don't think I would call that treatment.

Chairman **Rangel**. I wouldn't call it treatment at all——

Dr. **Mikuriya**. But I would say that the utilization——

Chairman **Rangel** [continuing]. But let's go back to what I was saying——

Dr. **Mikuriya** [continuing]. Would——

Chairman **Rangel**. If I was to tell you, "Forget treatment," I've tried the best I can; Scheuer has walked away from me; the Committee has; the administration has; treatment is out, not only out with the Federal Government, which it always has been, because you never heard Secretary Bowen talk about any treatment, as I recall, but that's partisan.

If the governors say treatment is out; if the cities say treatment is out, and they say that treatment is putting someone in jail, that's treatment, or the electric chair, then I'll request an appointment with you.

But if what we all are saying is that we have to educate, we have to prevent, we have to give access to treatment, we have to make people think something of themselves, wouldn't you hang tough with us in that fight before you go through your responses to my question——

Dr. **Mikuriya**. Absolutely.

Chairman **Rangel** [continuing]. And legalize everything?

Dr. **Mikuriya** [continuing]. If you can figure out a way to pay for it.

Chairman **Rangel**. But don't you understand, Doctor, even you began to mumble as Mayor Schmoke, when I asked you how you were going to pay for the drugs. You say it will be cheaper. Okay.

Dr. **Mikuriya**. No, I told you through transaction——

Chairman **Rangel**. You told me through a scholarship.

Dr. **Mikuriya**. Pardon me?

Chairman **Rangel**. That's what you told me, that we'll support the addict's habit through a scholarship.

Dr. **Mikuriya**. Well, this is when you bring up the——

Chairman **Rangel** [continuing]. Payment——

Dr. **Mikuriya** [continuing]. Of who couldn't afford this amount. Who could not afford the modest price of these drugs that would be available at perhaps one-tenth their criminal market value at the drugstore, at the pharmacy.

Then you asked me about, what about these other people? And so, I responded to what are we going to do about the people——

Chairman **Rangel**. My point is that treatment——

Dr. **Mikuriya** [continuing]. Who cannot afford it?

Chairman **Rangel** [continuing]. Is relatively inexpensive compared to the cost of what we do when we don't make treatment available.

Dr. **Mikuriya**. How do you know?

Chairman **Rangel**. Because it costs more to keep a rascal in jail in my penitentiaries than it does in treatment, I know that. It's a very expensive process locking up these people.

Dr. **Mikuriya**. Oh, that's true. That is indeed true.

Chairman **Rangel**. It is far more expensive, and everyone would agree, to put the money in the criminal justice system than it is to put it in the treatment system. So that——

Dr. **Mikuriya**. From many points of view, it is more expensive, you're right.

Chairman **Rangel**. So if you and I could agree that we got a lot of work to do for treatment, all I'm asking you to do is to back off of the legalization.

Dr. **Mikuriya**. Absolutely. I'd be more than happy to do that.

Chairman **Rangel**. Then let's work together. Let's work together, because my fear is that out of the frustration that we can't break our way out of, out of just giving up and saying nothing is going to change, I tell you, believe it or not, on January 1, no matter who wins the elections, it's going to be better.

Dr. **Mikuriya**. Yeah. Well, I'll believe it when I see it.

Chairman **Rangel**. It has to be better.

Dr. **Mikuriya**. You know, how many times have I heard these kinds of promises?

Chairman **Rangel**. Well, you got——

Dr. **Mikuriya**. How much rhetoric must we endure?

Chairman **Rangel** [continuing]. My attention. When someone like you starts talking about legalization, you frighten me to do more.

Dr. **Mikuriya**. Good. Good.

Chairman **Rangel**. So you got a commitment. Very good.

Dr. **Trebach**. Congressman Rangel?

Dr. **Trebach**. Just a few points here. First of all, those of us on the reform side of the table are not in full agreement. I don't happen to agree with Dr. Mikuriya my colleague and friend, on a lot of the things he said. But what I do want to tackle very briefly is the idea of maintenance. All right?

My view is that we should make a wide array of treatment available. I mean, it could include every kind of treatment talked about from our friends on the left side of the table, those who oppose legalization.

And we should help them do all these kinds of things. And we haven't mentioned one religion. One of my students is a born-again Christian. She runs a treatment program based on born-again

Christian principles, does not like the idea at all of any kind of drugs being given to anyone.

There are plenty of programs across the board, and one thing I've discovered about treatment people, and this presents a difficulty for you and me because we're not treatment people, is they are like ministers of a church. And their church has a lot of the truth and the other churches don't.

Now supposedly there's science attached to each of these treatment modalities, but what I've found is there's a fierce devotion to particular treatment modality they have. Now what we have in this country is mainly drug-free treatment. There is some attention to the notion that we should provide maintenance drugs in some cases, and you find that in oral Methadone.

But what we need is, from this new commission you're going to set up, is an analysis of the history of maintenance that will answer your questions. And you will find——

Chairman **Rangel**. I think you've got us confused. It's Mayor Schmoke who's setting up the commission.

Dr. **Trebach**. Okay. I hope you will, sir. I hope you'll back it. But here is an example of the type of idea that exists in the medical literature. Back in the twenties this question was put to a prestigious committee of British doctors.

Under what circumstances is it medically advisable to provide heroin and morphine to people addicted to those drugs. You admit that's within the range of what you're talking about?

Chairman **Rangel**. I haven't heard any doctors talk about that, you know. You've got your Ph.D. and——

Dr. **Trebach**. Well, do you want to hear what they said?

Chairman **Rangel** [continuing]. You've studied the subject matter.

Dr. **Trebach**. I'm quoting from doctors, sir.

Chairman **Rangel**. Don't do that. I want the doctors to come. When I asked Mayor Schmoke to give me a list of the people he wanted to testify in support of his position, we got, what, 20 names? How many M.D.s and psychiatrists? You know, a lot of Ph.D.s, and I respect it, but——

Dr. **Trebach**. Can I quote the Rolleston Committee to you?

Chairman **Rangel**. Listen, I don't want to belittle your profession. I respect the contribution you're making to the discussion. But I want to find out who's dealing with these addicts, who understands them, who understands their needs, and then ask whether or not they think that they can do a better job by exposing them to drugs that they're not already exposed to.

Now if they've written things like this, the record will remain open, so that it can be included as part of this record. And the only reason I'm spending more time with the doctors than the Ph.D.s is because I know these addicts. I live with them. We feel the pain. We feel the compassion.

And I just don't want to say that we're going to make a Federal program, expansion of Medicaid, subsidies and additional drugs available to them until we have found out whether or not we've made some type of effort to improve the quality of life of these people and to expose those that would lend themself to treatment.

I don't know the answer because there's a waiting list. And my God, there've been so many people that have called up for help and they get a busy or they come to me and they ask, you know, how can they wait 18 months? I have not one Federal rehab place I can send them, with all the influence of members of Congress. If it was my own son, I couldn't pick up the phone and call a Federal rehabilitation agency to have him get a bed.

Dr. **Mikuriya**. Lest we think that I'm just interested in maintenance and putting everybody on drugs, I'm a member of the Biofeedback Society of California and our national society that believes in seeking self-regulatory means. Improving and enhancing self-discipline.

Getting the message that the solution to the problem really lies within the individual and not reaching for some nostrum. And how can we get this message across in a comprehensive fashion to give equal time for those that say, "Reach for a pill for your headache," et cetera, et cetera. Which then translates into being vulnerable for being involved with illicit drugs later.

Chairman **Rangel**. You're right.

Congressman **Scheuer**. I would suggest that there's a very simple answer to that. Apply for a grant from the National Institute on Drug Abuse and demonstrate that biofeedback is effective in handling problems of any particular form of substance abuse. It would then have credibility and be introduced into the therapeutic methods being practiced by psychologists and other practitioners, including physicians.

It's very simple. If you think that that's a workable hypothesis, then we are very willing to fund new treatment ideas. We need new treatment ideas and we'd welcome them.

Chairman **Rangel**. And this is what Jim Scheuer has been trying to say all day, while I've tried to push him into legalization and decriminalization. He stayed away from the "L" and the "D" words and he was asking for new ideas. And this is the type of thing that we're talking about. I assure you that this panel may not be everything the media wants, but it has made a major contribution in terms of what we need.

I won't have any commission and I don't think you're going to find me talking about entertaining, debating, or discussing legalization. You can forget it. But for those people who are still willing to believe that this great country of ours has the ability to provide the resources to those people who need it, that we can really do some things in prevention and education, and get people to understand, as the Doctor said, that they have to think something about themselves.

I'm going to be reaching out and seeing whether or not we can come together with these new, with these exciting ideas and bring them to a new Congress. Don't you give up on your Congress. That's all you got, believe me. You heard it before and there's no place to go.

And I wish it was better. But when you give up and walk away, then there's no one prodding and pushing and getting angry and saying that we can do more. There's no one that's accepted that we can't do more and we can't do better. We need your guidance and we need your experience to push us in the right direction.

And even when we disagree, what difference does it make as long as we have the same common objective and that's to make it as close to a healthy world as we can. This has been a fantastic panel. I know Jim Scheuer joins with me in thanking you and the rest of the Committee as well as the rest of the entire Congress.

Congressman SCHEUER. And I hope, Mr. Chairman, that this is a beginning and that we'll be engaging in a process of introspection and communication and examination of all of the available options in order to get rid of this disastrous non-system that we have now into a system that works.

And any option out there, any alternative, any new departure is something that we ought to be studying and thinking about long and hard. And I want to congratulate you again for having commenced a system and commenced a process of communication and cross-fertilization. We'll all be the richer for it and I look forward to the next sessions.

Chairman RANGEL. Thank you. This Committee now will recess. We start off tomorrow morning with Doctor David Musto of Yale University, who will give us a review, a historic review. And we'll be meeting here at room 210, Cannon at 9 a.m. And I thank you for your patience.

[Whereupon, at 5:56 p.m., the Committee recessed, to reconvene at 9 a.m., Friday, September 30, 1988].

PREPARED STATEMENTS

STATEMENT

OF

THE HONORABLE CHARLES B. RANGEL

CHAIRMAN

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

FOR

HEARING ON

LEGALIZATION OF ILLICIT DRUGS

THURSDAY, SEPTEMBER 29, 1988

ROOM 210 CANNON HOUSE OFFICE BUILDING

GOOD MORNING LADIES AND GENTLEMEN. I AM CHARLES B. RANGEL, CHAIRMAN OF THE HOUSE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL.

TODAY AND TOMORROW THE SELECT COMMITTEE IS HOLDING A HEARING IN RESPONSE TO RECENT PROPOSALS BY A NUMBER OF PUBLIC OFFICIALS CALLING FOR THE LEGALIZATION OF DRUGS.

FOR ABOUT THE LAST FIVE YEARS I HAVE CHAIRED THIS SELECT COMMITTEE. AND DURING THIS TIME MY COLLEAGUES AND I HAVE WATCHED THE DRUG CRISIS IN AMERICA EXPLODE EXPONENTIALLY.

WE NOW SPEND ABOUT $140 BILLION A YEAR IN AMERICAN DOLLARS ON ILLICIT DRUGS. WE THEN TURN AROUND AND ABSORB ANOTHER $100 BILLION A YEAR IN LOST PRODUCTIVITY AND DRUG-RELATED CRIME. I AM NOT READY TO SPEND MORE OF THE AMERICAN PEOPLE'S MONEY ON DRUGS AND CRIME AND PROPERTY LOSS, WHICH IS WHAT WOULD HAPPEN UNDER LEGALIZATION.

WE HAVE WATCHED AS AMERICA HAS DEVELOPED A LOVE AFFAIR WITH COCAINE. IN THE 1980s ALONE, THE AMOUNT OF COCAINE COMING INTO THIS COUNTRY HAS MORE THAN TRIPLED. AND NOW OUR OBSESSION WITH COCAINE HAS EVOLVED INTO A FASCINATION WITH CRACK, A DANGEROUS COCAINE DERIVATIVE. THE GENERATIONAL

DRUG OF THE 1980s, CRACK HAS MANAGED TO STEAL MANY YOUNG LIVES AND DREAMS --- ESPECIALLY IN OUR INNER CITIES --- AS OUR CHILDREN KILL OTHER CHILDREN FOR A HIT OF THIS POWERFUL POISON.

WE HAVE WATCHED AS OUR COMMUNITIES --- UNDER SIEGE FROM WARRING DRUG TRAFFICKERS AND RAVAGED BY CRIME COMMITTED BY DRUG ADDICTS --- HAVE BEEN SLOWLY TAKEN OVER BY THIS FOREIGN-BASED MENACE. THE HEART, THE SOUL AND THE MIND OF OUR NATION FACES A FORMIDABLE FOE IN ILLICIT DRUGS, AND OUR NATIONAL SECURITY, ONCE THREATENED ONLY BY THE FORCES OF COMMUNISM, NOW FACES A NEW AND MORE DANGEROUS THREAT FROM THE DRUG CRISIS.

ILLEGAL DRUGS HAVE CUT DEEPLY INTO OUR PRODUCTIVITY. I AM CONCERNED ABOUT THE IMPACT OF DRUGS ON THE FUTURE OF THIS COUNTRY. BUT UNLIKE SOME OF THOSE WHO HAVE GROWN WEARY OF THIS CRISIS, I AM IN NO WAY READY TO GIVE UP AND SAY THAT WE HAVE FOUGHT THE FIGHT AND HAVE LOST THE WAR ON DRUGS. I AM NOT READY TO GIVE UP WHEN WE HAVE YET TO BEGIN THE FIGHT. WE HAVE NOT EVEN FIRED THE FIRST SHOT, SO HOW CAN WE HONESTLY CALL FOR AN END TO A WAR THAT WE HAVE NOT YET STARTED? WE ARE NOT FIGHTING A WAR ON DRUGS; NOT WHEN OUR MAIN FEDERAL DRUG ENFORCEMENT AGENCY HAS JUST 2,800 AGENTS WORLDWIDE. THAT'S NOT NEARLY ENOUGH SOLDIERS TO SEND INTO THIS BATTLE. WE ARE NOT FIGHTING A WAR ON DRUGS WHEN THOUSANDS OF OUR CITIZENS WHO NEED AND WANT DRUG ABUSE

TREATMENT ARE TURNED AWAY DAILY BECAUSE SPACES ARE NOT AVAILABLE.

TODAY AND TOMORROW; WE WILL HEAR FROM THOSE WHO SAY WE SHOULD AT LEAST DISCUSS A RETREAT. OVER THE LAST FEW MONTHS, MANY OF YOU MAY HAVE HEARD DISCUSSIONS AND SUGGESTIONS THAT WE SHOULD LEGALIZE DRUGS SINCE WE CANNOT CONTROL THEM. THAT HAS LONG BEEN AN IDEA PUSHED BY THOSE IN ACADEMIC CIRCLES AND ON TELEVISION TALK SHOWS. BUT WHEN SOME OF THE FAINT VOICES HEARD RECENTLY IN THIS CHOIR OF CONFUSION ARE THOSE OF PUBLIC OFFICIALS, I BECOME CONCERNED, AND THAT IS WHY WE ARE HERE TODAY FOR THESE HEARINGS.

WE NEED TO CLARIFY ONCE AND FOR ALL WHAT WE MEAN WHEN WE SAY LEGALIZATION, PUBLIC OFFICIALS ESPECIALLY HAVE A RESPONSIBILITY TO BE CLEAR AND THOROUGH IN PROPOSING SUCH A POLICY TO THE AMERICAN PEOPLE WHETHER.

I WOULD LIKE TO TAKE THIS OPPORTUNITY TO WELCOME EACH AND EVERY ONE OF THE MORE THAN 30 WITNESSES PREPARED TO TESTIFY BEFORE OUR PANEL IN THESE HEARINGS TODAY. ALTHOUGH I AM UNALTERABLY OPPOSED TO EVEN THE NOTION THAT WE SHOULD LEGALIZE ILLICIT DRUGS, I LOOK FORWARD TO RECEIVING YOUR TESTIMONY. I HOPE THAT WE CAN FIND SOME COMMON GROUND FROM THIS TO GO FORWARD TOGETHER TO DO WHAT REALLY NEEDS TO BE DONE TO EXCISE THIS CANCER FROM OUR SOCIETY.

FOR THOSE WHO WOULD SAY THAT WE OUGHT TO MAKE DRUGS LIKE COCAINE, HEROIN, MARIJUANA AND PCP AS LEGAL AND AS ACCEPTABLE AS SOAP AND CANDY, I HAVE PROPOSED A LONG LIST OF QUESTIONS. TO THIS DAY, I HAVE NEVER GOTTEN ANY REAL ANSWERS AND I INTEND TO BRING THOSE SAME QUESTIONS UP AGAIN TODAY.

WHAT KINDS OF DRUGS WOULD BE LEGALIZED? WOULD WE NOT HAVE TO LEGALIZE THE KILLER CRACK? WHO WOULD WE SELL THESE DRUGS TO? WOULD WE SELL THEM TO TEENAGERS AS WELL AS ADULTS? WILL YOU HAVE TO BE 18 TO BUY THEM, OR 21? WHERE WOULD THEY BE SOLD, IN YOUR NEIGHBORHOOD UPTOWN OR IN MINE DOWNTOWN? WHO WOULD PRODUCE AND MARKET THEM? WOULD THE MULTI-NATIONAL PHARMACEUTICALS TAKE OVER THE RESPONSIBILITIES OF MANUFACTURING AND DISTRIBUTION FROM WHAT WE NOW CALL THE "BLACK MARKET?" WOULD AMERICAN FARMERS TAKE OVER THE GROWING OF NARCOTICS CROPS?

I WANT TO KNOW, HOW MUCH COULD YOU BUY AND WHEN COULD YOU BUY IT? COULD YOU BUY ALL YOU WANT WHEN YOU WANT? WOULD THERE BE 24-HOUR DISPENSARIES FOR THOSE WHO NEED A FIX IMMEDIATELY? IF YOU'RE NOT AN ADDICT, COULD YOU BUY THESE DRUGS? IF YOU ARE AN ADDICT, DO YOU GET TO BUY MORE THAN THE PERSON WHO IS JUST "EXPERIMENTING?" WILL THESE DRUGS BE FOR JUST THE RICH WHO HAVE A STEADY INCOME AND CAN AFFORD IT, OR WILL WE HAVE "DRUG STAMPS" FOR THOSE WHO ARE JOBLESS AND WANT TO SATISFY THEIR CRAVING TOO?

CAN YOU TAKE A "COKE BREAK" DURING LUNCH ON THE JOB? WILL THE PILOT FLYING YOU FROM NEW YORK TO LOS ANGELES BE FRESH FROM A COCAINE HIGH THE DAY BEFORE? WILL THE MAN POWERING THE 18-WHEELER THAT WHIZZES BY YOU ON THE INTERSTATE PULL OUT HIS STASH HALFWAY DOWN THE ROAD AND COLLIDE WITH YOU?

IF WE HAVE DOCTORS PRESCRIBING THESE LEGALIZED DRUGS, WILL THEY GIVE YOU ENOUGH TO GET HIGH OR JUST ENOUGH TO FEEL GOOD? WHAT HAPPENS IF YOU OVERDOSE? WHO IS RESPONSIBLE? WILL DOCTORS BE ABLE TO GIVE OUT FREE SAMPLES? WHAT HAPPENS TO OUR HEALTH INSURANCE PLANS AND THE PRICE WE NOW PAY FOR THAT COVERAGE? CAN THESE DRUGS BE ADVERTISED ON RADIO, ON TV, ON BILLBOARDS, AT THE BALLPARKS AND ALONGSIDE CITY BUSES?

EVEN IF THE FEDERAL GOVERNMENT LEGALIZED DRUGS, THERE IS NO GUARANTEE THAT STATES AND LOCALITIES WOULD WANT TO DEAL WITH THIS AS A NEW NATIONAL POLICY. I DOUBT VERY SERIOUSLY THAT POLICYMAKERS AT THE NATIONAL LEVEL WOULD WANT TO FORCE SOMETHING AS RADICAL AS DRUG LEGALIZATION DOWN THE THROATS OF THE AMERICAN PEOPLE IF THEY DID NOT WANT IT. THE AMERICAN PEOPLE HAVE ALREADY SPOKEN ON THE SUBJECT, AND 90% SAID IN A RECENT SURVEY THAT THEY WERE OPPOSED TO THE IDEA OF LEGALIZATION.

MANY OF THOSE PUSHING THE LEGALIZATION ARGUMENT POINT TO THE FACT THAT MANY OF THE PROBLEMS WE FACED WITH ALCOHOL

ABUSE IN THE EARLY PART OF THIS CENTURY WERE ELIMINATED WITH THE END OF PROHIBITION. NOTHING COULD BE FURTHER FROM THE TRUTH. LOOK AT ALL THE PROBLEMS ASSOCIATED WITH ALCOHOL ABUSE THAT CONTINUE TO PLAGUE US TODAY.

WHILE THE NUMBER OF DEATHS PER THOUSAND FROM CIRRHOSIS OF THE LIVER DROPPED FROM 13.8 IN 1910 TO 7.7 RIGHT AFTER THE END OF PROHIBITION, TODAY, THAT FIGURE IS ABOVE 11 DEATHS PER 100,000. OUR GREATEST PROBLEM TODAY WITH ALCOHOL IS DRINKING AND DRIVING. ABOUT 10 TO 15 PERCENT OF ALL HIGHWAY FATALITIES IN THIS COUNTRY TODAY INVOLVE ALCOHOL USE.

WE MAY HAVE REMOVED A LARGE PART OF THE INFLUENCE OF THE UNDERWORLD THROUGH ENDING PROHIBITION, BUT THE TRUTH OF THE MATTER IS, THAT PEOPLE DIE EVERY DAY FROM ALCOHOL-RELATED TRAFFIC ACCIDENTS, CIRRHOSIS OF THE LIVER AND FROM DOMESTIC VIOLENCE TRIGGERED BY ALCOHOL ABUSE. HUNDREDS OF THOUSANDS OF AMERICANS ARE CONSIDERED "PROBLEM DRINKERS," AND YOUNG TEENAGERS LOOKING FOR ADVENTURE ARE TRYING BOOZE FOR THE FIRST TIME EVERY DAY, PROHIBITION OR NO PROHIBITION.

IF YOU WANT TO GET A FLAVOR OF WHAT LEGALIZATION WOULD BE LIKE, TAKE THIS COUNTRY'S DRUG PROBLEM AS IT EXISTS NOW AND MULTIPLY IT BY TWO OR THREE TIMES. ADDICTION WOULD RISE DRAMATICALLY. MORE PEOPLE WOULD TRY DRUGS FOR THE FIRST TIME BECAUSE THEY WOULD BE CHEAPER AND EASIER TO

OBTAIN, AND THE NUMBER OF PEOPLE WHO USE MORE THAN ONE DRUG COULD BE EXPECTED TO RISE SINCE THE ATMOSPHERE UNDER LEGALIZATION WOULD ENCOURAGE EXPERIMENTATION. WHO IS TO SAY THAT UNDER LEGALIZATION, YOU COULD NOT BUY SEVERAL SUBSTANCES AND MIX THEM TOGETHER? WE ARE ASKING FOR SOCIAL CHAOS AND DISORDER OF THE HIGHEST UNDER DRUG LEGALIZATION.

ONE NEED LOOK NO FURTHER THAN THE TURN OF THE CENTURY FOR HARD LESSONS ON LEGALIZED DRUGS AND THE DAMAGE THEY INFLICTED ON AMERICA. AS YALE DRUG HISTORIAN DR. DAVID F. MUSTO HAS POINTED OUT IN HIS RESEARCH, THE UNITED STATES WAS TERRIBLY AFFECTED BY A DRUG CRISIS IN THE LATE 1800s AND THE EARLY 1900s. OUR SOCIETY WAS WRACKED WITH HEALTH, SAFETY AND DOMESTIC PROBLEMS ASSOCIATED WITH THEN-LICIT DRUGS. AMERICA HAD ITS FIRST COCAINE EPIDEMIC. LEGALIZATION DIDN'T WORK THEN AND IT WON'T WORK NOW.

PERHAPS MOST IMPORTANT IN THESE DISCUSSIONS IS THAT UNDER LEGALIZATION, WE WOULD BE SENDING DISTURBING, MIXED MESSAGES TO OUR YOUNG PEOPLE. WE WOULD BE SAYING WITHOUT A DOUBT THAT USING DRUGS IS OKAY AND IS NOT A DANGEROUS PROPOSITION. WE WOULD BE SAYING TO A GENERATION OF LEADERS TOMORROW THAT IF WE IN AMERICA FEEL THAT WE FACE A TOUGH CHALLENGE THAT CANNOT BE MET FULLY AT THE MOMENT, THEN GIVE IN. IF YOU CAN'T BEAT THE OUTLAWS, JOIN THEM.

HOW COULD WE HONESTLY PROMOTE EDUCATION AND TREATMENT PROGRAMS ON THE ONE HAND WHEN ON THE OTHER WE ARE

ENCOURAGING THE VERY USE OF THESE SUBSTANCES THROUGH LEGALIZING THEM?

WE IN AMERICA HAVE COME THROUGH TWO WORLD WARS; WE HAVE FOUGHT VARIOUS OTHER CONFLICTS IN KOREA AND VIETNAM AND ELSEWHERE; WE HAVE PRESERVED AND PROTECTED FREEDOM AND JUSTICE; WE HAVE FOUGHT BACK PLAGUES AND NATURAL DISASTERS; WE HAVE OVERCOME LEGALLY-PROTECTED RACIAL INJUSTICE. WE HAVE EVEN LED THE EXPEDITION TO THE STARS AND THE MOON. YET, SOME OF US SEEM WILLING TO FOLD OUR TENTS AND GO HOME ON THIS ONE WITHOUT REALLY EVEN TRYING. THIS IS NOT THE AMERICA THAT I KNOW.

WHAT KIND OF LEADERSHIP LEGACY DOES THIS LEAVE? DOES THIS MEAN THAT IT IS OKAY TO LEGALIZE MURDER BECAUSE IT HAPPENS ALL THE TIME? IS IT OKAY TO GIVE IN TO THE COMMUNISTS BECAUSE THEY SEEM TO BE STANDING AT EVERY NATION'S DOORSTEP?

DRUG LEGALIZATION? NOT ON YOUR LIFE.

STATEMENT OF CONGRESSMAN BENJAMIN A. GILMAN
AT THE NARCOTICS SELECT COMMITTEE'S HEARING ON THE LEGALIZATION OF ILLICIT DRUGS

SEPTEMBER 29, 1988

OUR STRUGGLE AGAINST ILLEGAL DRUGS HAS BEEN CALLED A WAR. BUT IT IS A WAR WHICH AMERICA IS NOT WINNING. THE DRUG KINGPINS CONTINUE TO CASH-IN ON THIS NATION'S SEEMINGLY INSATIABLE APPETITE FOR DEADLY DRUGS. THESE MULTINATIONAL CRIMINAL SYNDICATES HAVE USED THEIR ILL-GOTTEN WEALTH AND UNRESTRAINED VIOLENCE TO BUILD A CRIMINAL EVIL EMPIRE OF BREATHTAKING GLOBAL MAGNITUDE.

THEIR POWER IS SO GREAT THAT THEY THREATEN THE AUTHORITY OF GOVERNMENTS THROUGHOUT THE WORLD. IN LATIN AMERICA THE SITUATION IS PARTICULARLY SERIOUS. COLOMBIA, HOME OF THE MEDELLIN AND CALI DRUG SYNDICATES, IS UNDER SIEGE. THE DRUG CARTELS HAVE BEEN RESPONSIBLE FOR THE ASSASSINATION OF THE MINISTER OF JUSTICE, THE ATTORNEY GENERAL, MORE THAN 50 JUDGES, AT LEAST A DOZEN JOURNALISTS, AND MORE THAN 400 POLICE AND MILITARY PERSONNEL. THOUSANDS OF COURAGEOUS COLOMBIANS CONTINUE TO WORK UNDER PRESIDENT BARCOS' LEADERSHIP TO COMBAT NARCOTICS IN SPITE OF DEATH THREATS TO THEMSELVES AND THEIR FAMILIES.

WHEN THE NARCO-TRAFFICKERS OFFERED THE COLOMBIAN GOVERNMENT A DEAL, PROMISING TO HELP PAY OFF THE DEBT IF THEY WERE LET OFF THE HOOK FOR THEIR CRIMES, THE PEOPLE AND GOVERNMENT OF COLOMBIA DID NOT SINK TO THE MORAL LOW-GROUND OCCUPIED BY THE DRUG DEALERS. THEY RESISTED THE FINANCIAL TEMPTATION. THEY REJECTED THE OFFER. THEY DID NOT SURRENDER TO THE DRUG KINGPINS.

NOW SOME IN THIS COUNTRY ARE CALLING FOR SURRENDER. THEY ARGUE THAT WE SHOULD COMPROMISE OUR MORALS, OUR VALUES AND THE LIVES OF THOUSANDS OF OUR CITIZENS BY LEGALIZING DRUGS. THEY TELL AMERICAN POLICYMAKERS TO GIVE UP THE MORAL HIGH GROUND. THEY SAY "COME ON DOWN, LET'S MAKE A DEAL." LEGALIZE DRUGS AND THE DRUG CRISIS WILL END. THAT'S AKIN TO ENDING VIOLENT CRIME BY LEGALIZING MURDER.

DRUG LEGALIZATION WILL NOT PUT THE INTERNATIONAL DRUG CARTELS OUT OF BUSINESS. PROHIBITION DID NOT END ORGANIZED CRIME. IT JUST FORCED A CHANGE IN PRODUCT LINE. IF WE LEGALIZE DRUGS, THE CARTELS WILL ADAPT. THEY WILL FIND NEW WAYS TO PENETRATE THE U.S. MARKET, CONTINUE THEIR BUSINESS OPERATIONS IN EUROPE AND ASIA, AND PERHAPS MOVE MORE EXTENSIVELY INTO GUNRUNNING AND TERRORISM. DRUG TRAFFICKING AND DRUG ABUSE IS NOT A PROBLEM THAT CAN BE SOLVED WITH THE STROKE OF A PEN.

NEITHER WILL DRUG LEGALIZATION END DRUG-RELATED STREET CRIME. IN AN ABC NEWS POLL THIS MONTH, 76% OF AMERICANS SAID LEGALIZATION WOULD NOT DECREASE CRIME. THE REASON THEY SAY THIS IS THAT THEY HAVE SEEN THE ADDICTS ON THEIR STREETS AND THEY UNDERSTAND THAT DRUG USERS DON'T STEAL, RAPE AND MURDER ONLY BECAUSE THEY NEED MONEY TO PAY FOR THEIR HABIT. THEY ALSO BREAK THE LAW BECAUSE THEIR JUDGMENT, STABILITY AND STATE OF MIND ARE

ERODED BY THEIR DRUG USE. DOES ANYONE REALLY THINK THAT, UNDER LEGALIZATION, THE CRACK ADDICT IS GOING TO GO IN TO A 24-HOUR A DAY DRUG SUPERMARKET, PICK-UP A "LEGAL" DOSAGE OF CRACK AND THEN STAY OUT OF TROUBLE? I DON'T THINK SO.

HOWEVER, JUST BECAUSE I OPPOSE LEGALIZATION, IT DOES NOT FOLLOW THAT I BELIEVE THAT OUR DRUG POLICY HAS BEEN EFFECTIVE IN REDUCING THE SUPPLY AND DEMAND FOR DRUGS. MANY OF THOSE WHO ADVOCATE LEGALIZATION CREDIBLY CRITICIZE PAST INADEQUACIES IN THE WAR AGAINST DRUGS. SO TODAY WE HAVE AN OPPORTUNITY TO FOCUS THE NATION'S ATTENTION ON THIS DEADLY PROBLEM.

I LOOK FORWARD TO TODAY'S TESTIMONY AND CONGRATULATE CHAIRMAN RANGEL FOR GIVING PEOPLE OF DIVERSE VIEWS A CHANCE TO SHARE THEIR THOUGHTS WITH THE AMERICAN PEOPLE ON THIS MOST IMPORTANT PROBLEM.

THANK YOU, MR. CHAIRMAN.

FORTNEY H. (PETE) STARK
9TH DISTRICT, CALIFORNIA

COMMITTEES:
WAYS AND MEANS
DISTRICT OF COLUMBIA
SELECT NARCOTICS

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D.C. 20515

Mr. Chairman,

I want to commend you on having the courage to hold these hearings. Through your bold leadership in fighting the illegal drug plague, you've kept hope alive for so many American families who have been impacted by this problem. You are a true unsung hero in our national 'war on drugs.'

I've had the pleasure of working with you on so many important, pressing issues over the past sixteen years, and I look forward to working together to seek new and creative solutions to this problem.

Mr. Chairman, we both represent cities, New York and Oakland, which have been heavily impacted by the drug plague. We see and hear of the daily destruction of illegal drugs in our areas. Our district's neighborhoods are the frontlines in our 'war on drugs'.

The cities of New York and Oakland share some common drug-related characteristics. Both cities are only able to treat 10% of heroin and cocaine addicts who seek critically-needed treatment and assistance. Both cities require these drug addicts to wait at least six months for treatment. Both cities have seen their drug-related crime rates skyrocket in recent years as a result of the glaring lack of available, affordable treatment. Both cities spend many times more funds and resources arresting users than concentrating on treating the addicted.

I believe legalization of illicit narcotics isn't the answer to the drug problem. But we must focus on treating the abuser so the residents of New York and Oakland will be able to feel safe again. Every time we turn away an addict, we're all accomplices to the crimes committed to maintain an expensive habit.

Mr. Chairman, before adjournment, I will introduce a bill to set up a trust fund to finance treatment for all addicts seeking help. "Treatment on request" is the best answer to lowering our cities' drug-related crime rate.

It will be financed through the social security program's disability insurance provisions and will use Medicare payment principles to provide a full range of cost-controlled inpatient and out-patient rehabilitation services. Simply put, "treatment on request" is a crime reduction program.

I welcome the opportunity to hearing today's witnesses -- it's important that we begin to focus on the health-oriented solutions and more humane approaches.

THIS STATIONERY PRINTED ON PAPER MADE WITH RECYCLED FIBERS

Outline of Legislation of Rep. Pete Stark (D-CA)
to be introduced in October, 1988
For Consideration and Discussion
before the
Select Committee on Narcotics Abuse and Control
September 29, 1988

The Drug Treatment and Crime Reduction Act of 1988

** Establishes an independent drug Treatment, Rehabilitation, and Elimination of Addiction Trust (TREAT) Fund.

** Under its terms, drug addicts would be able to seek both cost-controlled in-patient and out-patient treatment from a full range of state-licensed providers.

** TREAT fund monies would be paid to state-licensed providers using Medicare principles of prospective payments. Providers would be subject to Provider Review Organization surveys to ensure effectiveness of treatments and ensure cost controls.

** Persons seeking help would be required to contribute to the costs, based on a progressive-income scale. Addictions are treated much more effectively when addicts invest in their own health and well-being.

** Studies would be conducted to determine the most effective forms of treatment, and whether it would be cost-beneficial to extend such services to alcoholics and those wishing to quit smoking.

** The program would define drug addiction as a disability and accept the notion that treatment for addiction should be made universally available to all in need.

** The program would be financed through increases in the wage base of the Disability Insurance portion of the Social Security payroll deduction -- currently shared equally by both employees and employers.

** By investing in addiction treatment, we'd all benefit through lower law enforcement costs, lower health insurance and crime insurance rates, increased worker productivity, and a "war on drugs" with a chance at victory.

Opening Statement
Congressman Solomon P. Ortiz
Select Committee on Narcotics Abuse and Control
Thursday, September 29, 1988

MR. CHAIRMAN, IN THE INTEREST OF TIME I WILL KEEP MY OPENING STATEMENT BRIEF.

BEFORE BECOMING A CONGRESSMAN, I SERVED AS A SHERIFF IN SOUTH TEXAS.

AS SUCH, I SAW MANY BRAVE AND DEDICATED MEN AND WOMEN SACRIFICE THEIR TIME, THEIR EFFORT, AND OFTEN, THEIR LIVES IN FIGHTING WHAT WE CALL THE WAR ON DRUGS.

BUT, IT IS A TRAGIC COMMENT ON THE EFFECT THAT ILLICIT DRUGS HAVE HAD ON THIS COUNTRY WHEN REASONABLE PERSONS ARE DRIVEN TO SERIOUSLY CONSIDER UNREASONABLE PROPOSALS.

AND I REMAIN CONVINCED THAT WHEN ALL IS SAID AND DONE, WE WILL REALIZE THE TRAGICALLY MISGUIDED NATURE OF ADMITTING DEFEAT IN A WAR WE HAVE BARELY BEGUN TO WAGE.

THE WAR ON DRUGS IS NOT JUST ABOUT MONEY OR THE ECONOMICS OF A BLACK MARKET.

IT'S ALSO ABOUT HUMAN POTENTIAL AND OUR POTENTIAL AS A PEOPLE.

I RECOGNIZE THE POSITION OF THOSE WHO FEEL WE MUST OPENLY DEBATE THIS TOPIC.

THAT IS WHY WE ARE ENGAGED IN THIS HEARING.

THESE DRUGS TAKE AWAY THE GOD GIVEN GIFT OF HUMAN POTENTIAL.

THEY POISON AND DESTROY THE BODY, THE MIND, AND THE SOUL.

WHEN EVEN ONE MORE CITIZEN FALLS PREY TO THE ADDICTION OF THESE SUBSTANCES, WE ALL SUFFER AS A SOCIETY.

LEGALIZATION WOULD NOT CHANGE THIS.

WHY WOULD SOMEONE LAY DOWN THEIR LIFE FOR THIS PURPOSE?

CERTAINLY, A SENSE OF DUTY TO ENFORCE THE LAW OF THE LAND IS A PRIMARY MOTIVATION.

BUT THERE IS MORE TO IT THAN THAT.

THOSE WHO SO BRAVELY WAGE THIS WAR ALSO KNOW WHAT ILLEGAL DRUGS ARE DOING TO OUR CHILDREN, OUR COMMUNITIES, AND OUR NATION AS A WHOLE.

Cardiss Collins

STATEMENT BY
REP. CARDISS COLLINS
AT THE HEARING ON LEGALIZATION OF DRUGS BY THE SELECT COMMITTEE ON NARCOTICS, SEPTEMBER 29, 1988

A college student visits a nearby newspaper stand and buys a magazine plus a pack of cigarettes....marijuana cigarettes. A crane operator stops by the drug store nearest her home before work and buys a two-gram vial of cocaine. A grade-school teacher, who prefers to imagine his students as well-behaved young ladies and gentlemen, regularly keeps a box of L.S.D. cubes in his desk.

These are scenarios which could easily become reality if we were to legalize illicit drugs. Is this desirable? My answer is a resounding, "NO!"

Nonetheless, the idea of legalizing drugs is very interesting and I applaud you, Mr. Chairman, for holding this hearing today. The concept behind legalization is definitely worth probing and the proposal to legalize has greatly increased interest in and debate on the drug problem. The proponents of legalization must also be commended as they are trying hard to ~~solve~~ grapple with the drug problem rather than standing by, wringing their hands, waiting for someone else to think or act.

Drugs have become one of the greatest public evils in the United States in recent years. Although most of us have been well aware of this problem's magnitude for many years, the present Administration has demonstrated a profound lack of similar understanding. Nancy Reagan tells us to "Say No" to drugs while President Reagan says no to developing an effective policy which will lead to the rapid eradication of this blight on America. Substance abuse is deeply rooted and cannot be solved by a mere slogan. Hopefully, the recent Floor activity on the drug issue has awakened the Administration to the pressing need for addressing this crisis before it develops into utter catastrophe.

Although I could not support it on final passage due to passage of the Gekas death-penalty amendment and the Lungren exclusionary-rule amendment, the Omnibus Drug Bill takes decisive action in numerous arenas and with numerous approaches. But one which it does not adopt is the altogether legalization of illicit substances. This is a truly radical option which I do not believe should be selected at this time, although its discussion will offer insight into the drug problem.

Plainly stated, legalization is a gamble. Moreover, it is a long-range gamble. Drug-related violence and criminality could conceivably decrease during the initial phase of legalization; although that may be an improper assumption if there is an increase in intoxicated individuals on the streets. But, as concerns drug abuse, it seems incontrovertible that the immediate effect of legalization would be rampant usage for at least a short while. How long that initial phase would last is, of course, anyone's guess: perhaps a week, a month, or a year. If legalization were to have the desired effect, it would not be a success until after the lion, who has been captive for many years, becomes accustomed to his liberty.

The next question is, "Can we afford to wait that long?" Again, my answer to this is a resounding, "Absolutely NOT!" The initial phase of legalization, during which the lion is let out of the cage and substance abuse becomes rampant, could very well have permanent, debilitating consequences for America. First of all, a prolonged period of substance abuse has been proven highly capable of inflicting irreparable damage on the brain and body of the abuser. Second, habits and needs may be established, even by persons who had intended to sample certain drugs only a few times. Third, any sustained period of substance abuse may easily result in a landslide of industrial and vehicular accidents. Fourth, our productive capacity could take a nose-dive -- in terms of both quality and quantity --

from which it would be very difficult to rebound. Fifth, it could generate a complex constitutional and legal quagmire of protecting the newly-legal rights of individuals while implementing law enforcement and school/corporate policies which contain abuse. Perhaps most importantly of all, drug legalization could impair our youth who obtain drugs [redacted], dulling the minds and dampening the spirits of our country's future leaders. And there would be other consequences which are difficult to foresee.

Even if we were to erroneously assume that these consequences could be absorbed, the idea of eventual success is still purely speculative. To suggest that this is the ultimate solution to the complex problem of drug abuse is tantamount to a flailing stab at human nature which, as we all know, wears different faces at different times. The "human nature" notion that Americans would, over time, avoid drug-induced self-destruction can be countered with the equally plausible notion that it would be adopted into the culture just as alcohol, caffeine, and nicotine have been. Diminution of the problems of drug crimes and accidents is similarly speculative, since increased abuse could spawn an increase in these incidents, even though trafficking problems may substantially decrease.

Nonetheless, Mr. Chairman, I appreciate your calling this hearing because it considers a viewpoint which is integral to the national debate on the Drug War. Furthermore, the idea of legalization is one from which a lesson can be learned: that of combatting an evil by trying to make it less evil, rather than by throwing the entire arsenal at it. I look forward to an enlightening presentation of views and approaches today. Thank you.

Brad

OPENING STATEMENT OF THE HON. DANIEL K. AKAKA
SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL
Thursday, September 29, 1988

Thank you very much. Mr. Chairman, I am pleased that you have presented this forum today, whereby arguments on both sides of the aisle can be heard on the proposal to legalize drugs. You have been a most able and compassionate chairman in combatting our nation's drug problem, and you are to be commended for your leadership.

I would like to welcome all of our witnesses today and to thank you all for your preparation and time. The very mention of the word "legalization" stirs up an emotion in many of us, and it is important that we have this opportunity to voice and listen to all arguments.

The issue today is not to sanction the use of drugs, but to question whether legalization can break the stranglehold that drugs have on our community, or if it would serve as the impetus that suffocates our society.

The pervasion of our drug problem is past alarming--it is deadly. We have long contended that drugs affect all of us, not just the user and the pusher. And never has this been more apparent than today as we read the daily news. Our homes are being broken into by addicts looking for fast cash, innocent bystanders are shot at in drug feuds, minors lured by cash are being killed in turf wars, and passengers have been killed because of drug-impaired operators.

Personally, I am against legalization. Nevertheless, if a viable solution can be recommended, I am willing to listen. I look forward to hearing from our witnesses today.

OPENING STATEMENT OF CONGRESSMAN DANTE B. FASCELL (D.-FLA.) DURING THE HEARINGS HELD BY THE HOUSE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL ON PROPOSALS TO LEGALIZE DRUGS

SEPTEMBER 29, 1988

Mr. Chairman and fellow members of the House Select Committee on Narcotics Abuse and Control, I am certain that we all agree that the use of, and the traffic in, illegal drugs is one of the most pernicious threats facing our nation today. Such activities fuel our crime rate and have a devastating impact on the lives of individuals and on our society as a whole.

Our fight against the scourge of drugs must focus on interdiction, education and rehabilitative treatment. We in the House have just passed a tough, comprehensive omnibus anti-drug abuse bill, but, no matter how vigorously we attack this pervasive problem, for our fight to be successful, we, as a society, must reduce the demand for drugs.

There are always many proposals put forward to deal with a problem of this magnitude and we are here today to examine proposals to legalize drugs. I believe we do need to have this discussion and pay careful attention to the views which are expressed. I do not believe that the legalization or decriminalization of drugs is a solution to the drug problem, and it would take a pretty powerful argument for me to change my mind.

A clear connection between crime and drugs is well established and documented. While a tremendous number of individuals commit crimes in order to either get drugs or the money to purchase them, a large number of those individuals arrested for nondrug related crimes have also been found to have used drugs prior to the crimes they committed. Legalization will not solve this problem; it will only compound it by making it easier to get drugs.

We can only win the war on drugs by reducing demand and changing a large segment of this nation's attitude toward the use of drugs. We must attack this problem head on, and, in my view, legalizing drugs sends both a misguided and contradictory signal. If we were to legalize drugs, how can we convince the youth of our nation not to start using drugs? How can we urge other countries to work with us in drug interdiction and eradication efforts?

The consequences of this nation's drug epidemic affect each and every one of us. We must increase aid to state and local law enforcement agencies and we must have real coordination of efforts among all U.S. government agencies in anti-drug efforts both at home and abroad. We must concentrate our efforts on drug interdiction, demand reduction, rehabilitation and education. Legalizing drugs, in my judgment, will accomplish none of the above.

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SEPTEMBER 29, 1988
U.S. REP. CARROLL HUBBARD
TESTIMONY
"LEGALIZATION OF DRUGS"
SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

MR. HUBBARD. MR. CHAIRMAN AND MY COLLEAGUES, I DEEPLY APPRECIATE THIS OPPORTUNITY TO TESTIFY HERE THIS MORNING. I WOULD LIKE TO EXPRESS MY GRATITUDE TO, AND MY RESPECT FOR, CHAIRMAN CHARLIE RANGEL OF NEW YORK AND THE MEMBERS OF THIS SELECT COMMITTEE FOR HOLDING HEARINGS ON THIS VERY CRUCIAL ISSUE. IT IS MY GOAL TO PARTICIPATE IN THE WAR ON DRUGS, AND I BELIEVE THE CONSIDERATION OF LEGALIZATION OF DRUGS WILL ONLY MAKE AN ALREADY FORMIDABLE ENEMY MORE INVINCIBLE. THERE IS NO MORE TIME TO WASTE. THE WAR ON DRUGS MUST CONTINUE. A WAR OF ACTION AND NOT OF SLOGANS, AND I FIRMLY BELIEVE THIS WAR CANNOT TAKE PLACE UNTIL WE REASSESS OUR PRIORITIES AND GET THEM IN ORDER.

THE SUBJECT MATTER OF TODAY'S HEARING IS ONE OF THE MOST IMPORTANT ISSUES FACING THE FUTURE OF OUR GREAT LAND, AND IF NOT TREATED WITH A DECISIVE, RESPONSIBLE ATTITUDE, COULD PROVE TO HAVE THE GREATEST NEGATIVE IMPACT OUR NATION COULD EVER HOPE TO ENDURE. THE POTENTIAL LEGALIZATION OF DRUGS, OR ANY SUBSTANCE THAT IS TERMED "ILLEGAL" IN TODAY'S SOCIETY, WOULD BE THE MOST

HARMFUL SOLUTION TO A PROBLEM THAT YIELDS THE GREATEST INHUMANE SERVICE TO MAN. THE CONSIDERATION OF LEGALIZING ANY DRUG IS A STEP NOT ONLY IN THE WRONG DIRECTION, BUT IN A DIRECTION THAT WOULD ONLY RESULT IN MORE VIOLENCE, MORE DEATH, MORE CORRUPTION, AND I STRONGLY FEAR WOULD RESULT IN A NATIONAL NIGHTMARE FROM WHICH WE MAY NEVER WAKE.

I PROUDLY REPRESENT OVER 550,000 FINE WESTERN KENTUCKIANS IN THE CONGRESS, AND I AM CONFIDENT THAT MY CONSTITUENTS ARE READY AND WILLING TO PARTICIPATE IN A WAR AGAINST DRUGS AND AGAINST THOSE INVOLVED IN THE ILLEGAL DRUG INDUSTRY. I DO NOT BELIEVE, HOWEVER, THAT THIS WAR WILL BE WON BY LEGALIZING THAT WHICH WE SEEK TO ELIMINATE. THE WAR ON DRUGS WILL NEVER BE WON AND WILL INEVITABLY BE LOST IF WE CONTINUE TO AVOID CONFRONTATION THE REAL PROBLEM BY OFFERING DISTORTED SOLUTIONS. I MAINTAIN THAT WE MUST ESTABLISH A STRATEGY TO CRUSH THIS DESTRUCTIVE INDUSTRY THAT HAS BECOME A WAY OF LIFE AND DEATH FOR TOO MANY AMERICANS.

PROPOSALS TO LEGALIZE THE USE OF DRUGS, IN ANY FASHION, SEND THE WRONG MESSAGE TO OUR YOUTH, AND CONSEQUENTLY ADOPTION OF SUCH PROPOSALS WILL HOLD OUR YOUTH RESPONSIBLE. I AM CONFIDENT THAT NOT ONLY WILL THESE PROPOSALS OPEN THE DOOR

TO AN INDUSTRY THAT HAS CLAIMED THE LIVES AND SPIRIT OF THE POTENTIAL LEADERS OF OUR NATION, BUT THEY WILL STEAL THE VERY HOPE UPON WHICH OUR NATION DEPENDS.

MR. CHAIRMAN AND MEMBERS OF THIS SELECT COMMITTEE, I CANNOT CONSIDER THE LEGALIZATION OF DRUGS A VIABLE ALTERNATIVE TO THE OVERALL PROBLEM. IT IS IMPOSSIBLE FOR ME TO THINK OF ANYTHING POSITIVE THAT HAS EVER COME FROM DRUG USERS, ABUSERS, AND DEALERS, AND IT BECOMES EVEN MORE UNREASONABLE FOR ME TO CONSIDER REWARDING THESE OUTLAWS AND THEIR SO CALLED BUSINESS BY CONSIDERING PROPOSALS TO BENEFIT THEM. I CAN'T IMAGINE DEALING WITH THESE CRIMINALS MUCH MORE DEALING WITH THEM ON A "LEGAL" BASIS.

IN SUMMATION, I WOULD LIKE TO EXPRESS MY SINCERE FEAR OVER THE VERY THOUGHT OF THE LEGALIZATION OF DRUGS. I HAVE DEALT WITH THE WRATH AND HORROR OF THIS VIOLENT INDUSTRY, AND THE VIOLENCE THAT THIS BUSINESS BESTOWS. I HAVE LIVED THROUGH THE THREAT ON THE LIVES OF MY FAMILY AS WELL AS THE THREAT OF MY OWN LIFE FOR MY PARTICIPATION IN BRINGING DRUG DEALERS TO JUSTICE. THE FIRST TELEPHONE CALL I RECEIVED THIS YEAR WAS AT 10 AM ON JANUARY 1. IT WAS A CALL FROM THE CAPITOL HILL POLICE TO TELL ME I HAD RECEIVED A DEATH THREAT FROM DRUG DEALERS IN BOWLING GREEN, KY., BECAUSE I HAD TESTIFIED IN BOWLING GREEN LAST DECEMBER ABOUT DRUG DEALERS IN BOWLING GREEN AND WARREN COUNTY, KENTUCKY. I HAD TESTIFIED BEFORE THE WARREN COUNTY GRAND JURY. I CAN, WITH ALL CONFIDENCE TELL YOU HERE TODAY, THAT LEGALIZATION OF DRUGS WOULD NOT ONLY BE A HARSH ERROR IN JUDGMENT, BUT A CRUEL INJUSTICE TO HUMANITY.

AGAIN, I WOULD LIKE TO THANK CHAIRMAN RANGEL AND THOSE OF YOU ON THIS SELECT COMMITTEE FOR THE OPPORTUNITY TO TESTIFY HERE TODAY.

REMARKS: CONGRESSMAN ROY DYSON

DATE: SEPTEMBER 29, 1988

TIME: 9:30 A.M.

RE: DECRIMINALIZATION OF DRUGS

Mr. Chairman, distinguished members of the Select Committee on Narcotics Abuse and Control, and ladies and gentlemen. I am grateful for the opportunity to share with you some of my thoughts on an issue which is of vital concern to me-- drugs in America. I think a discussion of this issue is good for America, and hopefully will generate new ideas to help us to win the war on drugs. However, I do not believe the decriminalization of drugs is a viable proposal that warrants consideration. It is a foolhardy and reckless proposal, which would have a serious impact on our society, and most importantly, the American family. However, since the issue has been presented, I feel obligated to express my strong opposition to any attempt to decriminalize narcotics in the United States.

In a primarily rural district in the State of Maryland, you would not expect to find a serious drug problem or a high crime rate. Unfortunately these two problems do exist and are increasingly becoming interrelated. In just one of my Counties alone, the number of drug offenses increased 114% between 1986 and 1987. This might be expected in urban areas like New York City, or Washington, D.C., but not in Rural America, where family, church, little league baseball games, and weekend picnics have traditionally been the most important things in people's lives. Now drugs have invaded this sanctuary and are fast becoming part of every community.

As many of us recall, it was not more than twenty years ago when many people in our country, including such notables as Professor Timothy Leary, poet Alan Ginsburg, and activist Jerry Reuben, were extolling the pleasurable aspects of heroin, LSD, and other hallucenogenic drugs. They said drugs were harmless and that people should be free to use them; that drugs would help people escape the hardship of the real world. But are drugs harmless? Should people be free to use them ? Do they allow people to escape the hardship of the real world? The answer to all three questions is a resounding no. During the last twenty years, we have seen the cruel nature of drugs; the lives it has ruined, the lives it has ended. We know that drugs do not make someone free, but instead, make them a slave to a master which has no mercy. A master which has no compassion. A master which demands total subservience. A master which guarantees misery and financial ruin. To decriminalize drugs would be to enslave additional Americans to a life of misery, rather than offering a helping hand to those in need of our assistance.

Unfortunately, when we should be exploring new ideas to win this war, some officials, including my good friend Mayor Kurt Schmoke of Baltimore, would like us to return to an old idea called decriminalization, which is a backdoor attempt to legalize the purchase, sale, and use of drugs. If we were to remove the legal sanctions against drugs, the drug laws would not be worth the paper they are written on. Therefore, let me make it perfectly clear, I will strongly oppose any effort to weaken our drug laws, whether it originates at the federal, state, or local level. I will do everything in my power to help those millions of addicts win their battle with drugs, and will not add to their misery by providing them with drugs. As the Mayor of Philadelphia, W. Wilson Goode recently stated, "We are in this war for the long haul, and we are in this war to win it."

Decriminalization would not alleviate the drug problem in the United States. Instead, it will increase our problems. It would send a message to our nation's children that drugs are acceptable. It would mean that the numbers of suffering addicts would increase, as would the number of grieving families. It would mean streets lined with addicts. It would mean billions of dollars of additional health care costs, as well as billions of dollars in lost worker productivity. This is something neither America nor it's citizens can afford.

Mr. Chairman, today we are at a crucial point in our efforts to win the war on drugs. It is a transition period between previous failures and future successes. Though illegal drug use is widespread throughout our society, there are some glimmers of hope. More students today are aware of the dangers of drug use than ever before, and marijuana use among High School Seniors has actually decreased, even though it is still alarmingly high.

I have no allusion that a renewed effort to win the war on drugs will be easy, and I realize it will take a considerable amount of time and money. But I strongly believe that saving the lives of our nation's youth from the scourge of drug use is worth the effort.

To begin to address this issue, we must start to teach our children, beginning in kindergarten and continuing through to the twelth grade, the harmful effects of drug use. In addition, we need to better educate parents to identify the symptoms of drug use and the sources of assistance available to them.

Though education must play a large role in any effort to eradicate drugs from our society, I believe stiff sanctions must also be applied to those who grow, use, sell, or transport illegal narcotics. If this means the death penalty for some drug pushers, so be it. I recently supported the federal death penalty amendment to the Omnibus Drug Bill. I think if the drug dealer is responsible for someone's death, the drug dealer should pay with his life. The House took another step in the right direction when it approved an amendment to the bill which would prevent a person convicted of drug-related offenses from obtaining federal grants, loans, contracts and housing for a period of five years. I believe these actions let drug pushers know that Congress is serious about winning this war. But let's make sure we have a coordinated effort, not one which fluctuates due to the political climate.

Mr. Chairman. I believe we can win the war on drugs, and I plan to work as hard as I can to ensure this victory. This is one war we cannot afford to lose. Mr. Chairman, I would like to once more thank you for the opportunity to present my views to this distinguished Committee, and I look forward to working with you on both current and future legislative initiatives to combat this widespread problem. Thank you.

TESTIMONY OF REP. BENJAMIN L. CARDIN
BEFORE THE SELECT COMMITTEE ON NARCOTICS
SEPTEMBER 29, 1988

Mr. Chairman, I would like to thank you for the opportunity to testify here today, and I would like to congratulate you for convening these hearings to address the drug problem in our nation.

For the past month -- in anticipation of this hearing -- I have held a series of Drug Forums throughout the Third Congressional District. My purpose was to get the feel and tenor of my constituents and to be able to accurately transmit their views about our drug problem to this Committee.

First,.I want to congratulate Mayor Kurt Schmoke for focusing the national spotlight on the ineffectiveness of our current drug effort. But I must add that I believe any effort to decriminalize drug use would be counterproductive.

As the representative for a large portion of Baltimore City, Baltimore County and Howard County, I would like the record to show that in a recent survey of the Third Congressional District 69% of respondents opposed any decriminalization of drugs.

Throughout the Third Congressional District, I have found confusion over the ideas of legalization and decriminalization. Many constituents have expressed what retired police officer John Singleton of Northeast Baltimore said: "We cannot win a war against drugs unless we take the profits out, but decriminalization is not the way to do it."

I have attached testimony submitted to the Committee by Scott McGregor, one of the leaders in Baltimore's Athletes Against Drugs program. Both Scott McGregor and Tippy Martinez are here with us today. Mr. McGregor, Mr. Martinzez and other Baltimore athletes visit local schools to talk about the dangers of drug use with school children. He thinks the debate on legalization hurts his efforts. "Our kids have been told that what is illegal is wrong and what is legal is right. Now if we tell them it's legal they'll be confused and we'll be sending a mixed message to them."

Baltimore has traditionally been a city of neighborhoods, where families spend long hours socializing on their front stoops or porches. Our drug epidemic is threatening this way of life. At a recent South Baltimore Drug Forum, more than 100 residents talked about the gangs of youths that hang around dealing drugs on the street corners and in alleys.

"How can we wage a war on drugs when kids roam the streets selling drugs and we are afraid to go out of our homes?" one South Baltimore resident asked me at a Drug Forum. "We want to help ourselves but we need support from our neighbors, the police and the government," said another South Baltimore resident.

And it's true, they do need the help and support of our government. According to Mary Deboeser, chairman of the South Baltimore Improvement Committee, "a full-time drug and alcohol program is desperately needed in the community for adults as well as the younger generation. There are at this time no available treatment programs for adolescents in our community. "

Mrs. Deboeser raises a very important issue: in our rush to talk about our national drug crisis we cannot forget the damage done by alcoholism. In every single one of my Drug Forums, constitutents talked about the entire range of substance abuse issues. From drugs to alcohol to cigarettes, constituents in my District want resources allocated for preventing and combating all substance abuse.

The First Step Youth Services Center in Randallstown, Maryland, is an example of a community-based, and government-supported, program that is successful in stopping drug use. For a little over one thousand dollars per person , First Step works with more than 60 "at risk" adolescents and their families; this is only a fraction of the $50,000 a year it costs to incarcerate a drug offender.

First Step's drug rehabilitation program has a success rate of 75%. Unfortunately, the center also has a 3 1/2 month waiting list for treatment. A recent report by the Justice Department found that a person on the waiting list for drug treatment commits an average of one crime every other day. We cannot afford to delay funding all necessary drug treatment programs.

Over and over again at these Drug Forums I heard the same refrain: We are tired of the drug epidemic and we want our Federal government to do something about it. At a Drug Forum in Northwest Baltimore, Chip Silverman, special adviser to Governor William Donald Schaefer on drugs, summed it up best when he said: "We have given lip service to the war on drugs. There are currently 600,000 dysfunctional substance abusers in Maryland. Education is the only way to change society's attitudes towards drugs and education takes money."

And it does take money to institute effective education and treatment programs if we are going to wage a real war on drugs. At a Howard County Drug Forum, Dr. Joyce Boyd, Howard County's health officer, complained that "the lack of priority given to treatment programs means that drug treatment counselors are paid at such a low scale, many are eligible for food stamps." Dr. Boyd went on to add that "resources are so limited that volunteers are used to man treatment centers that should be staffed by professionals."

My constituents want a real war on drugs, a war that will reach all segments of our society. On hearing about the effectiveness of drug education programs in the schools, one Columbia resident brought up a good point: "I am concerned about the young people not reflected in that survey -- the drop outs. How do we reach them?"

And how do we reach the poor, those drug dependent individuals who depend on Medicaid? Ginny Thomas, a member of the Maryland House of Delegates, made an important point at a Drug Forum: "Currently there is no Medicaid reimbursement for inpatient drug treatment." Let's be realistic, many individuals with serious drug problems need inpatient treatment -- treatment that those dependent on Medicaid cannot obtain.

Throughout the Third Congressional District I see people getting mad about our drug epidemic. George Layman of Howard County said, "If we have a war on drugs, put teeth in the laws, otherwise it might as well be legal." And one senior citizen said: "There is a need for a return to teaching ethics in our schools. The 'me' generation doesn't understand you just can't live for yourself; you have a responsibility to your community."

And he is right, every American has a responsibility to his community. And we as a Congress have a responsibility to the nation to do all we can to rid our communities of drugs without trampling civil liberties and due process of law. Mark Antell of Howard County expressed it best when he said: "I am concerned about the danger in eroding our civil liberties in waging a national war on drugs. We should declare a war on drugs, not a war on the Constitution."

Despite the absence of a consensus, I do think a theme developed in the comments voiced at the drug forums. A resident of Arbutus probably summed up this theme best when he said, "The addict has a health problem; the pusher has a criminal problem."

There's no easy answer to this problem. We need to adopt a comprehensive approach to substance abuse that includes a foreign and domestic policy sensitive to the urgency of interdiction efforts, stricter enforcement of existing laws prohibiting drug activity, more resources to educate our youth to the dangers of illicit drugs, and treatment programs without waiting lists to get people off drugs.

Mr. Chairman, members of the committee, I thank you for the opportunity to appear before the Committee today, and I again congratulate you for today's hearings and for your continued efforts in the field of drug abuse.

SCOTT McGREGOR

September 29,1988

Congressman Cardin

Re: Statement on behalf of'Athletics Against Drugs- Join our Team'

Dear Honorables,

For two years we have visited and poured ourselves into the city of Baltimore and we are preparing now for the third year. We have through much effort come to the children to tell them we love them andinfluence them against the hideous monster of drugs. We have shared that it's not possible to be an athlete on drugs, family life is impossible on drugs, job life is impossible on drugs. But mainly that drugs are illegal and that jail and lose of career are their rewards. That is why we as athletes are so stronly opposed to the decrimnalization of drugs. Are kids have been told that whats illegal is wrong and whats legal is right. Now if we tell them it's legal they'll be confused and we will be sending a mixed message to them. Uncertainty is the curse of authority and our kids today need authority like never before.

Athletes who are now the leaders to these kids will become the wrong role models to these kids if drugs become decriminalized. Because the athletes of today are the ones with all the money and will buy the most drugs and will invariably will turn to the kids. The heros that we have become as athletes telling these kids what to do must not be tarnished anymore that is why we don't agree with this hideous bill that would make more available drugs in the city.

Recently the NBA has started a new drug testing program and the NFL and Major League Baseball need one. In this day where professional athletes are having more and more problems with drugs we can't give them more. That is why we feel we need to make a strong statement to Mayor Schmoke and all those interested in this bill, by thus removing our 'Athletes Against Drugs' program from Mayor Schmoke administration. We don't feel it possible any longer to continue with this program since our positions are so conflicting.

Scott McGregor

3RD DISTRICT DRUG FORUMS

SUBMITTED BY:
JOHN T. WEIGLE
3 BOURBON COURT
BALTIMORE, MARYLAND 21234

To qualify my following comments it is important for the reader to understand that they come from a police officer who has witnessed the end results of drug abuse; is an instructor currently involved in a drug education prevention program; and an individual who has lost two family members to drug abuse.

If we want to consider the decriminalization or legalization of drugs in this country, we don't have to look hard for examples of how totally devastating and tragic the consequences can be. The repeal of prohibition did not stop organized crime and the violence of bootlegging mobsters as repeal proponents had predicted. Without losing a step, mobsters simply shifted to other criminal activities, pushing other drugs like heroin and cocaine. It was also predicted by those same experts that people needing treatment for alcoholism would receive it, and that their numbers would decrease. The well known facts that after 50 years of legalizing alcohol in this country, we now have an estimated 20 million alcoholics; treatment which costs our economy billions each year and cannot keep up with the growing numbers. Consider the ramification of uncontrolled use of cocaine, which some experts consider 100 times more addictive than alcohol and with an estimated ratio of 4 out of 5 regular users becoming hopelessly controlled by the drug.

Despite federal and state controls placed on the sale of alcohol to minors, alcohol related accidents are the number one killer of American teenagers. The increased availability of drugs to adults would, inevitably increase use by our youth and cause even more carnage.

Even though 75% of Americans use alcohol, we are making progress in slowing down the use and abuse among our youth. This is being done not by abolishing the minium drinking age, but through the implementation of nationwide alcohol educational programs in many of our school systems. Our teenagers are not giving up, more and more of them are getting involved in S.A.D.D. Chapters, alcohol free after prom parties, and alcohol peer counseling groups.

Many legalization proponents say the first drug that should be cut loose for general use is the supposedly harmless marijuana, which they repeatedly say has never killed anyone. I guess they don't know about the 116 victims of the Chase Amtrak crash, caused by one person's use of a combination of marijuana and PCP. Present studies strongly indicate that as many as one third of people involved in traumatic or fatal traffic accidents have THC in their systems. These same proponents surely do not know that a person who is high on marijuana experiences almost the identical debilitating physical effects as the alcohol intoxicated driver. Over 300,00 Americans die each year from the damage that tobacco causes to our hearts and respiratory systems. This death rate does not even come close to the possible damage of wide spread marijuana use, due to the fact that it deteriorates the respiratory system approximately 5 times faster than tobacco, and has two times the amount of Cancer causing agents contained in its smoke. If you analyze the true consequences of the European countries that have legalized marijuana, you find, contrary to predictions, that its use increased along with the use of the so-called harder drugs.

Most experts involved in drug treatment and the medical field agree on one inevitable horrible consequence of legalization; that is drug use would more than double in this country. As a result the number of destroyed lives, the lost productivity to this nation's economy, and the cost of treatment for so many new abusers, would be devastating.

If legalization or decriminalization is not the answer to save America from its self-destruction with drugs, then what can we do to stop the devastation?

Law enforcement officials versed not only in the criminal but social aspects of the drug dilemma understand the key to winning our war on drugs is through a two pronged front. The first being drug enforcement, cutting the supply which will eventually stop the trafficers already in operation. Law enforcement agencies are imporving on this front, and will continue to inflict even more damage provided certain trends are followed. First local and federal funding to drug enforcement is increased in proportion to the need. The continuance of seizures of drug dealers' assets impacts them where it hurts the most, and providing funding for drug education, treatment and enforcement. In essence, the dealers are paying for their own downfall and not the taxpayers.

Battling the supply side of the drug war is fruitless without attacking the reason for it, which is the demand. Economists know that any business which does not have a demand for its product is surely doomed. Preventive drug education programs which have only been in existence nationally for about four years are proving to be our most effective weapon in the drug war. Programs such as D.A.R.E. (Drug Abuse Reisstance Education) will have three million graduates nationally by the end of this school year. The immediate results of these programs are that thousands of teenagers are turning away from drug involvement by their own choice. This persuasive negative peer pressure towards drug involvement among D.A.R.E. graduates in particular is even hard to comprehend for the program's initiators. The impact of these programs was supposed to be long range; however, they are extremely successful now, with a predicted phenomenal future.

Finally, the legalization of drugs which we know are physically debilitating and addictive to a large number of people is too high a price to pay for any reason. Law enforcement officers in this country who are fighting and dying on the front lines of the drug war are not willing to give in to the drug dealers, making deadly drugs available to the general public will include our children and we cannot afford to sacrifice them. Law abiding Americans in this country are not willing to throw in the towel, I hope our elected officials don't either.

Statement of Honorable Kweisi Mfume
Representative in Congress from the State of Maryland
Before the Select Committee on Narcotics Abuse and Control

September 29, 1988

Good morning, and thank you Mr. Chairman. I would like to express my sincere appreciation to the Members of the Select Committee on Narcotics and especially to you, Mr. Chairman, for your leadership and efforts in seeking a sound and rational approach to dealing with the problem our nation is experiencing with drug use, abuse, and trafficking. In particular, I would like to thank the Committee for this opportunity to contribute my ideas in an effort to further the debate on this issue.

Mr. Chairman, Let me preface my remarks by stating for the record that I am strongly opposed to the concept of legalization. It is, however, extremely important for this debate to take place, even though we may discuss unfavorable solutions and undesirable affects, than to allow for us to fall into a realm of misinformation, false hope, and disillusionment--especially when the nation looks to those of us in Congress for leadership and guidance.

Mr. Chairman, There is no doubt that both proponents and opponents on both sides of the issue agree that drugs are tearing the Nation apart by the seams. In fact, there is no issue more important or threatening to the our society than that of the flow of illicit drugs into our streets and communities. It has been estimated that 23 million Americans use an illegal drug at least once a month and six million of these use cocaine. Drug abuse affects victims of Americans from all social, racial, economic, and ethnic backgrounds. Although chemical addiction is not a new problem for us, it now has the potential to do even greater damage because drug use is so prevalent among teenagers and young adults. High school students, college students, and other young adults in the United States use illicit drugs to a greater extent than young people in any other industrialized nation in the world.

I can understand, that out of frustration and dismay about the pandemic use of drugs in the country, many will seek alternative solutions to failed policies. However, I am ardently opposed to the proposal of legalizing narcotics no matter how well intentioned.

Some argue that legalization or decriminalizing drugs as we know them, will in effect take the profit out of the drug trade. And it may in fact do just that. However, let me say to you, and remind myself, that although the drug trade is driven by profit, drug use and abuse are driven by demand. And it is reduction of that demand to which I believe greater national attention must be given.

Legalizing drugs in my opinion, will have detrimental effects on the very young people we are trying to protect. Past experiences with alcohol proves that a drug that is legal for adults cannot be kept from reaching kids. I believe that under any proposal to legalize or decriminalize, more and more of our children would experiment with drugs. Studies have found that more exposure and curiosity leads to more usage which in turns leads to more and greater addictions. It has been estimated that 75 percent or more of all regular drug users become addicted. Already we have seen the devastating affect drugs have had in communities where exposure probabilities are significantly higher. An approach again, in my opinion, aimed at decriminalization serves to exacerbate the problem rather than to alleviate it. Legalizing drugs is not the answer. It creates more questions than there are answers. As the Chairman has previously asked, "Who will get the drugs?, What drugs will be dispensed?, In what communities will they be made available?, and, How would we deal with the inevitable increase in new users and addicts?" just to name a few.

More disturbing is the fact that we just don't know what would be the effects of legalization in our society. Proponents are forgetting the fact that the greatest impact will fall upon America's greatest resource-- our young people. At present, we can only speculate what the outcome of legalization would be. Some persons point to England and Holland where legalization has been experimented. The result in England have led to a stronger and more vibrant black market as well as an increase in the number of heroin users--a policy which had to be eventually eliminated by the British government. In Amsterdam, where marijuana is legal and other illicit drug use is tolerated, crime remains a problem and those individuals addicted to "hard" drugs continue using them. Drug legalization has not worked in other countries and there is increasing probability that it will not work in ours. Additionally, more and more babies are born in this country addicted to drugs. How can we dispense drugs under a concept of legalization, when it is already apparent that chemically dependent mothers continue to use drugs even during pregnancy? We must not allow an entire generation of children to be lost as a result of a proposal that we can only speculate will be effective.

During the 1800's, we witnessed a dramatic rise in the uses of **opiates**, in the 1960's an increase use of heroin and marijuana, and the mass appeal of cocaine in the 1970's which has blossomed into America's drug of preference today. The scope of the problem is very much different today than in the past. We are faced with the realities of the **negative** impact drugs import to our society. We have seen a dramatic increase in drug-related crimes, highway and train accidents which involve drug use, and continued drug-related corruption. The real solutions do not lie in legalization because the root of the problem is not found in **criminality**. Drug abuse is the result of social and economic strife. Particularly in the urban community where drugs have had a **devastating** effect on our youths. In these areas, the problem of drug abuse is further magnified by the problems of teenage pregnancy, unemployment, lack of adequate education and reduced opportunity for improvement. The dropout rate is as high as fifty percent in some areas. Incessantly, by their sophomore year in high school, a large number of these individuals are turning more toward drug use and trafficking. In order to attack the problems of drugs, we must put our resources where they are desperately needed to alleviate the plight of these individuals and others by attempting to reduce the demand for drugs. **Economically**, without demand-- supply is useless. Let us not fall into the trap of searching for easy "quick-fix" answers that the notion of legalization provides for a complex and compounded problem that is driven by demand.

Attempts at reducing the supply of drugs produced by other countries has approached the problem from a one-dimensional aspect and has not realized our goal. Even though we have had a dramatic increase in seizures of drugs entering the country and more convictions of drug traffickers, there has been little or no affect on the availability of drugs on the streets. We have placed too much emphasis on supply-side strategies of crop eradication and interdiction. Addressing the problem only from this perspective certainly will not be enough.

I do not dispute the importance of both strategies in our efforts to combat drugs, but they should not be the limit of our scope. We must broaden our programs to cover every aspect of drugs from the time it is harvested, before it reaches the streets, and after it has impacted communities.

Mr. Chairman, we will have to extend our efforts to drug prevention and treatment programs. Drug addiction is a public health problem. Deterring our young from using drugs and helping those who are already chemically dependent in conjunction with supply-side tactics is the most promising joint strategy we can explore. Substance abuse treatment programs in the United States are too few in number and too meager in resources to adequately satisfy augmenting needs. However, recent innovative attempts in the treatment field brings promising new opportunities. This is an area where we must broaden our research to seek ways in which to reduce an individual's desire for drugs and help them to lead drug-free lifestyles. If this is a war on drugs, the battle field is not in Columbia or Bolivia, rather the fight will have to commence in our schools, in our homes, and at our work places. We must bring together educators, parents, health practitioners and community leaders to develop effective ways to convince our population at greatest risk from using drugs. We have already seen appropriately designed prevention and treatment programs work. Clearly the need to develop additional basic programs which replicate these is crucial.

Information programs in particular should be directed both towards youths who are not using drugs as well as those who have had an initial drug experience. A school-based approach as well as community-oriented programs will be needed in ever increasing numbers to offset the powerful influences our children experience outside the classroom. Studies have indicated that programs designed to promote personal and social skills are effective in preventing the abuse of alcohol, marijuana, and other drugs. We will have to target our efforts in those areas where our youth are at considerable higher risk to be exposed to drugs.

As a Nation at risk, we **must** make a landmark commitment to effectuating charge on the demand side of the drug equation. If this is in fact a "war on drugs", we may have to consider a change in strategies, but we must not give up in defeat through legalization. I believe that over the next few years, the tide will turn on drugs as we seek new preventive and treatment methods coupled with tough new laws on drug use, abuse, and trafficking.

Again, I thank the Chairman for his years of leadership on this tough and painful issue, and I look forward to hearing the testimony of our distinguished guests today.

Testimony of the Honorable Kurt L. Schmoke

Submitted to

The U.S. House of Representatives

Select Committee on Narcotics Abuse and Control

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"The addict is denied the medical care he urgently needs, open and above-board sources...are closed to him, and he is driven to the under-world where he can get his drug, but of course surreptitiously, and in violation of the law..." (from American Medicine, 1915)[1]

The foregoing observation was made 73 years ago on the heels of the passage of the Harrison Narcotics Act. It hasn't aged a day. As the writer was quick to recognize, the effectiveness of the Harrison Narcotics Act - the federal government's first attempt to stamp out the use of narcotics (and other drugs incorrectly labeled narcotics) - is hampered by two inescapable facts. First, addiction is a disease and, whether we want to admit it or not, addicts need medical care. And second, in the absence of access to legitimate sources of drugs for medical care, a criminal underworld will quickly step into the breach and sell the addict the drugs that he or she cannot otherwise obtain.

Since the Harrison Narcotics Act was first passed, the United States has made herculean efforts to try to get around the reality that drug prohibition increases crime without doing away with addiction. Nevertheless, that reality remains as true today as ever. We have spent nearly 75 years and untold billions of dollars trying to square the circle, and inevitably we have failed.

That is not to say that there have been no drug-related changes since 1914. There are now more kinds of drugs (crack and PCP, to name two) and more potent drugs. There are more addicts (heroin addiction has doubled since 1914[2]), and as is apparent to anyone living in a major city, there is more crime. Much more. The only thing there is less of now than in 1914 is hope - hope that law enforcement can bring an end to this long national nightmare.

It is sometimes said that the United States has no drug policy. That is both true and untrue. We do have a drug policy, and it can be stated with almost child-like simplicity. Our policy is zero use of all illicit drugs all the time. Among Schedule I drugs, few distinctions are made as to physical harm or psychological effects. It's a policy that is both unambiguous and unimaginative. It is also unattainable. And in that sense, zero use, or zero tolerance as it is sometimes called, is not a policy at all -- it's a fantasy.

There is, however, an alternative to a drug policy based primarily on law enforcement, and it is an alternative that has worked before. The repeal of alcohol Prohibition helped rather than hurt this country, and a measured and carefully implemented program of drug decriminalization would do the same.

The case for decriminalization is overwhelming. But that is not to say that it is without risk. Providing legal access to currently illicit substances carries with it the chance - although by no means the certainty - that the number of people using and abusing drugs will increase. But addiction, for all of its attendant medical, social and moral problems is but one evil associated with drugs. Moreover, the criminalization of narcotics, cocaine and marijuana has not solved the problem of their use. Twelve million Americans used cocaine at least once in 1985.[3] And marijuana use is estimated to be at least twice that number.[4] According to the General Accounting Office, Americans in 1987 bought 178 tons of cocaine, 12 tons of heroin and 600,000 tons of marijuana.[5] Overall, millions of Americans are regularly using illegal drugs. Their reasons may vary, as do their race, income level and ability to quit. Nevertheless, in asking the criminal justice system to put an end to this tragic reality of American life, we have, quite simply, asked it to do the impossible.

While some may disagree, I believe the unwelcome honor of the worst drug-related evil goes to crime and the disintegration and demoralization of our cities - an evil that only the decriminalization of drugs has any chance of solving.

Except for libertarians - which I am not - advocates of decriminalization do not base their position on a belief that people have an inherent right to use drugs. On the contrary, advocates of decriminalization simply view it as preferable to our present policy.*

Decriminalization is a means to a much desired end: getting the criminal justice system out of the business of trying to control the health problem of drug abuse and putting that responsibility where it belongs - in the hands of our public health system. This is by no means a new idea.

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* In a Drug Policy Workshop held in Baltimore on August 4, 1988, both sides of the decriminalization debate expressed their views and shared their research. Topics for the workshop included public health, crime, and ethical considerations. A summary of the proceedings of the workshop is attached to this testimony.

In 1936, August Vollmer, who in the course of his career served as a police chief, professor of police administration and president of the International Association of Chiefs of Police wrote:

> *Drug addiction, like prostitution and liquor, is not a police problem; it never has been and never can be solved by policemen. It is first and last a medical problem, and if there is a solution it will be discovered not by policemen, but by scientific and competently trained medical experts whose sole objective will be the reduction and possible eradication of this devastating appetite.*[6]

August Vollmer was right in 1936 and he's still right.

To understand why our criminal justice system has not only failed to solve the problem of drug abuse, but has made it worse, requires some historical perspective.

Why are some drugs illegal? To answer that question many Americans might be tempted to borrow a line from Tevya in Fiddler On The Roof, "I don't know why, but it's a tradition." The point is, few of us can remember a time when narcotics, cocaine and marijuana were legal in this country, let alone remember (or know) what social forces led them to be made illegal. (That is not to say that Americans aren't aware that Coca-Cola originally contained cocaine; that heroin was once sold legally as a patent medicine; that marijuana was smoked widely in Colonial America and similar historical artifacts.)

In the 19th century opium based drugs, as well as cocaine and marijuana, were easily accessible and widely prescribed by physicians in the United States.[7]

The first attempt to ban opium came in 1875 when the City of San Francisco passed an ordinance closing Chinese opium smoking dens. The ordinance was not passed out of any concern about addiction. The concern was - at least to those who wrote the ordinance - that the Chinese opium dens were being frequented by white women and men of "good family."[8]

Thus, our long and unsuccessful effort to use the criminal law as a way to prevent people from using drugs arose out of 19th century America's obsession with race.

The Harrison Narcotics Act was passed in 1914. But again, this first federal anti-drug law was not an effort to fight addiction, or for that matter, drug traffickers. Two years earlier at the Hague Convention, the United States and the other countries signed a new treaty in which each of the signatories agreed to regulate opium traffic within their own borders.[9]

Accordingly, in order to meet its treaty obligations, Congress approved the Harrison Narcotics Act -- a law that was never intended to prohibit the use or sale of narcotics and cocaine.[10] On the contrary, the law simply required that anyone who manufactured, sold or prescribed narcotics be licensed and pay a fee. The law also imposed standards for quality, packaging and labeling.[11]

How did a law that on its face was no more than an economic regulation, become the statutory basis for making drug abuse the responsibility of the criminal justice system - at a cost of untold billions? The answer to that has to do with the nature of addiction.

The Harrison Narcotics Act specifically allowed doctors to prescribe and dispense narcotics "in the course of his professional practice."[12]. The medical establishment took the position, and still does, that addiction is a disease. (In July 1988, the AMA reiterated its long held view that addiction is a disease.) The Treasury Department, however, saw it differently. The Supreme Court, in the case of Webb v. U.S.,[13] settled the matter. The Court held that it was illegal for a doctor to prescribe narcotics for the sole purpose of keeping the addict comfortable.[14] In other words methodone maintenance, i.e. long term management of addiction, could not, and still cannot, be administered by private physicians. This was an astounding decision at the time it was made because it went against both commonly accepted medical norms and the apparent intent of Congress. As a result of the Webb decision and others, the legal market for narcotics dried up, leaving only the black market as a source for addicts to purchase drugs.

Since 1914, the United States has spent billions of dollars trying to rid itself of the black market in drugs. This is doubly ironic. First, because it was the passage of the Harrison Narcotics Act that allowed the black market to come into existence to begin with. And second, because the federal government's response to the black market since 1914 has been to intensify its efforts at prohibition. In other words, the very policy which created the black market has been used for almost 75 years to try and get rid of it. With that sort of approach, it's not difficult to understand why the importation, manufacture and sale of narcotics continues to flourish.

Our current drug policy is destined to fail and ought to be changed for precisely the reasons suggested by American Medicine in 1915.[15]

To begin with, addiction is a disease. In the words of the American Medical Association, "It is clear that addiction is not simply the product of a failure of individual will power...It is properly viewed as a disease, and one that physicians can help many individuals control and overcome."[16]

The nature of addiction is very important to the argument in favor of decriminalization. We cannot hope to solve addiction through punishment. As pointed out in the 1972 Consumer Union's Report on drugs,[17] even after prolonged periods of incarceration, during which they have no access to heroin, most addicts are still defeated by their physical dependence and return to drugs. Moreover, the results are pretty much the same when addicts leave a therapeutic treatment setting such as Synanon. The sad truth is that heroin and morphine addiction is, for most users, a lifetime affliction that is impervious to any punishment that the criminal justice system could reasonably mete out.

Given the nature of addiction - whether to narcotics or cocaine - and the very large number of Americans using drugs (The National Institute on Drug Abuse estimates that one in six working Americans has a substance abuse problem),[18] laws restricting their possession and sale have had predictable consequences - most of them bad. What follows is a summary of just some of those consequences.

1. Crimes Committed by Addicts

Addicts commit crimes in order to pay for their drug habits. According to the Justice Department, 90% of those who voluntarily seek treatment are turned away.[19] In other words, on any given day, nine out of every ten addicts have no legal way to satisfy their addiction. And failing to secure help, an untreated addict will commit a crime every other day to maintain his habit.[20]

Whether one relies on studies - such as the analysis of 573 narcotics users in Miami, who during a 12-month period were shown to have committed "6000 robberies and assaults, almost 6700 burglaries...and more than 46,000 other events of larceny and fraud"[21] - or simple observation, it is indisputable that drug users are committing vast amounts of crime and non-drug using Americans are frequently the silent victims of those crimes. Baltimore, the city with which I am most familiar, is no exception to this problem. According to James A. Inciardi, of the Division of Criminal Justice at the University of Delaware, a 1983 study of addicts in Baltimore showed that, "...there were high rates of criminality among heroin users during those periods that they were addicted and markedly lower rates during times of nonaddiction."[22] The study also showed that addicts committed crimes on a persistent day-to-day basis and over a long period of time.[23] And the trends are getting worse. Thus while the total number of arrests in Baltimore remained almost unchanged between 1983 and 1987, there was an approximately 40% increase in the number of drug-related arrests.[24] This increase, which is no doubt due in part to the increase in cocaine distribution and use, was taking place at the same time the federal government was increasing its enforcement and interdiction efforts.

On the other hand, statistics recently compiled by the Maryland Drug and Alcohol Abuse Administration indicate that crime rates go down among addicts when treatment is available. Thus, for example, of the 6,910 Baltimore residents admitted to drug abuse treatment in Fiscal year 1987, 4,386 or 63% had been arrested one or more times in the 24-month period prior to admission to treatment.[25] Whereas, of the 6,698 Baltimore City residents who were discharged from drug treatment in Fiscal year 1987, 6,152 or 91.8% were not arrested during the time of their treatment.[26] These statistics tend to support the view that one way to greatly reduce drug-related crime is to assure addicts access to methadone or other drugs without having to resort to the black market. As Professor Ethan Nadelmann points out, "If the drugs to which addicts are addicted were significantly cheaper - which would be the case if they were legalized - the number of crimes committed by drug addicts to pay for their habits would, in all likelihood, decline dramatically."[27]

2. Overload of the Criminal Justice System

If the last 74 years have proved nothing else, they have proved that we cannot prosecute our way out of the drug problem. There are several reasons for this, but the most basic reason is that the criminal justice system cannot - without sacrificing our civil liberties - handle the sheer volume of drug-related cases.

Nationwide last year, over 750,000 people were arrested for violating drug laws.[28] Most of these arrests were for possession. In Baltimore, there were 13,037 drug-related arrests in 1987. Between January 1, 1988 and July 1, 1988, there were 7,981 drug-related arrests.[29] Those numbers are large, but they hardly reflect the annual total number of drug violations committed in Baltimore. Should we therefore try to arrest still more? Yes - as long as the laws are on the books. But as a practical matter, we don't have any place to put the drug offenders we're arresting now. The population in the Baltimore City Jail is currently 2,900 inmates. The capacity of the Baltimore City Jail is only 2,700 inmates. This shortage of prison space has led to severe overcrowding, and the City is now under court order to reduce its jail population.

The extent to which drug crimes consume prison space can be seen in Baltimore City. Of the total Baltimore City jail population, 700 persons, or about 25%, are incarcerated for possession and/or possession with intent to distribute. However, it is estimated that 80% of the Baltimore City jail population is incarcerated for drug related crimes.

In jurisdictions outside of Baltimore, the numbers are just as bad, or worse. In New York City, for example, drug-law violations accounted for 40% of all felony indictments, and in Washington, D.C., the number was 50%.[30]

Our federal prison system has similar problems. It was built to house 28,000 prisoners and now has 44,000, one-third of whom are there on drug charges.[31] Fifteen years from now, it is expected that half of the 100,000 to 150,000 federal prisoners will be incarcerated for drug violations.[32]

Will more prisons help? Not in any significant way. We simply can't build enough of them to hold all of America's drug offenders - which number in the millions. And even if we could, the cost would far exceed what American taxpayers would be willing to pay.

Decriminalization is the single most effective step we could take to reduce prison overcrowding. And with less crowded prisons, there will be less pressure on prosecutors to plea bargain and far greater chance that non-drug criminals will go to jail - and stay in jail.

And then there is this related question: How many predatory crimes of violence are going uninvestigated, unprosecuted and unpunished because of the enormous effort being put into the war on drugs? We may never know. But, regardless of whether the number is large or small, it is the individual citizen and our communities that are paying the price of that neglect.

The unvarnished truth is that in our effort to prosecute and imprison our way out of the war on drugs, we have allowed the drug criminals to put us exactly where they want us: wasting enormous resources - both in money and personnel - attacking the fringes of the problem (the users and small time pushers), while the heart of the problem - the traffickers and their profits - goes unsolved.

In a nutshell, we're only arresting, prosecuting and incarcerating the tip of the iceberg; nevertheless, that tip is far larger than we have the capacity to handle.

3. Failed Supply Side Policies

Not only can we not prosecute our way out of our drug morass, we cannot interdict our way out of it either. Lately there have been calls for stepped up border patrols, increased use of the military and greater pressure on foreign governments. Assuming that these measures would reduce the supply of illegal drugs, that reduction would not alleviate the chaos in our cities and might make it worse.

Simple numbers explain why stepped up interdiction is unlikely to have much effect on demand. According to statistics recently cited by the AMA, Latin America produced 162,000 to 211,400 metric tons of cocaine in 1987.[33] That is five times the amount needed to supply the U.S. market. Moreover, we are probably only interdicting 10 to 15 percent of the cocaine entering this country. Thus, even, if we quadrupled the amount of cocaine we interdict, the world supply of cocaine would still far outstrip U.S demand. The statistics on opium are equally unnerving. Between 2,000 and 3,000 tons of opium were produced in 1987. And yet only 70 tons are needed to satisfy the U.S. demand for heroin.[34] In other words, the U.S. demand for opium is no more than 3.5% of the total amount produced. With that much of an oversupply, improved interdiction may increase the perceived risk to producers and importers, which may, in turn, increase the price. But it is not going to even begin to dry up the black market in heroin or cocaine. (Cocaine traffickers have had such success recently in smuggling their product, that the street price of cocaine is actually dropping.)

If the drug laws of the United States simply didn't achieve their intent, perhaps there would be insufficient reason to get rid of them. But our drug laws are doing more than not working - they are violating Hippocrate's famous admonition: first do no harm.

The legal prohibition of narcotics, cocaine and marijuana demonstrably increases the price of those drugs. For example, an importer can purchase a kilogram of heroin for $10,000. By the time that kilogram passes through the hands of several middlemen (wholesalers, retailers and purchasers), its street value can reach $1,000,000.[35] Those kinds of profits can't help but attract major criminal enterprises willing to take any risk to keep their product coming to the American market.

The situation with cocaine is worse. In a 1979 analysis cited in The Cocaine Wars,[36] a DEA agent demonstrated how $625 worth of coca leaves would have a street value in the United States of $560,000.[37] The analyst further calculated that if Columbia processed fourteen metric tons of cocaine per year, a number he considered conservative, it would produce almost $8 billion a year in potential revenue from raw materials only worth $8 million.[38] One year after that estimate was made, "the best estimate of the size of the Bolivian coca crop was 58,275 metric tons,"[39] a number almost twice as large as the number upon which the original DEA analysis was based. That meant that the Columbian drug cartels could look forward to even larger profits than were first feared by the DEA. Is it any wonder that Columbia has been virtually taken over by the drug traffickers, and that the unprecedented violence and corruption associated with cocaine that began in South America has now been brought to the cities and streets of the United States?

The fact is that the United States in the last ten years has become absolutely awash in cocaine, and tougher laws, greater efforts at interdiction, and stronger rhetoric at all levels of government and from both political parties have not, and will not, be able to stop it.

As we learned during alcohol Prohibition, when the government bans a substance that millions of people are determined to use - either out of foolishness, addiction or both - violent criminal syndicates will conspire to manufacture and sell that substance. And they'll do so for one simple reason: enormous black market profits. Punishment won't deter the trade and neither will internecine conflicts (including murder) among the traffickers. Such conflicts are just a way of reducing the competition. Drugs are a multi-billion dollar business, and as long as that's the case, willing buyers will always be able to find willing sellers.

4. Victimization of Children

Perhaps the biggest victim of our drug laws are children. Many, for example, have been killed as innocent bystanders in gun battles among traffickers. Furthermore, while it's true that drug prohibition probably does keep some children from experimenting with drugs, almost any child who wants drugs can get them. Keeping drugs outlawed has not kept them out of children's hands.

Recent statistics in both Maryland and Baltimore prove the point. In a 1986-1987 survey of Maryland adolescents, 13% of eighth graders, 18.5% of tenth graders and 22.3% of twelfth graders report that they are currently using drugs. In Baltimore City, the percentages are 16.6, 16.5 and 20.3, respectively.[40] It should be noted that these numbers exclude alcohol and tobacco, and that current use means at least once a month. It should also be noted that these numbers show a decrease from earlier surveys in 1982 and 1984. Nevertheless, the fact remains that drugs are being widely used by students. Moreover, these numbers don't include the many young people who have left school or those who failed to report their drug use.

A related problem is that many children, especially those living in the inner city, are frequently barraged with the message that selling drugs is an easy road to riches - far easier than hard work and good grades. Drug pushers, with their wads of money, become envied role models for young people who are seduced into joining the illegal trade. In Baltimore, as in many other cities, small children are acting as lookouts and runners for drug pushers, just as they did for bootleggers during Prohibition. Decriminalization and the destruction of the black market would end this most invidious form of child labor.

As for education, decriminalization will not end the "Just Say

No" and similar education campaigns. On the contrary, more money will be available for such programs. Decriminalization will, however, end the competing message of "easy money" that the drug dealers use to entice children. Furthermore, decriminalization will free up valuable criminal justice resources that can be used to find, prosecute and punish those who sell drugs to children.

5. Spread of Aids

The 1980's have brought another major public health problem that is being made still worse because of our drug laws: AIDS. Contaminated intravenous drug needles are now the principal means of transmission for HIV infection. The users of drug needles infect not only those with whom they share needles, but also their sex partners and their unborn children.

One way to effectively slow this means of transmission would be to allow addicts to exchange their dirty needles for clean ones. However, in a political climate where all illicit drug use is condemned, and where possession of a syringe can be a criminal offense, few jurisdictions have been willing to initiate a needle exchange program. This is a graphic example, along with our failure to give illegal drugs to cancer patients with intractable pain, of our blind pursuit of an irrational policy.

6. Helping the Smugglers; Ignoring the Addicts

The drug laws of the United States are self-defeating in ways both large and small. As previously stated, the most visible effect of our 74 year effort to criminalize the use of drugs has been the intolerable level of violent crime (committed by both addicts and traffickers) that has befallen our cities.

But our drug laws are self-defeating in other ways. One has to do with the art of smuggling. It is easier to smuggle small amounts of highly concentrated drugs than larger amounts of less concentrated drugs. Consequently, as our interdiction efforts have increased, drug traffickers have turned to smuggling purer forms of their product. For example, the average purity of cocaine has risen from 12 to 60 percent since 1980.[41] A similar increase has been found for heroin. (In 1967, a study by Arthur D. Little suggested that the concentration of heroin could be increased by over 1000 percent thereby greatly reducing its bulk.)[42] Also traffickers are switching from marijuana to cocaine, both because of the higher profits and because cocaine is easier to smuggle.[43] That, in turn, may be contributing to the burgeoning domestic supply of marijuana.

Our drugs laws hurt us in still another, even more subtle, way. Addicts, particularly those living in poor neighborhoods, have long been social outcasts. We seem to care little about their health and well being. That is a harsh judgment on our society, but it's hard to avoid, considering that there are 500,000 heroin addicts and millions of cocaine users, and yet we take no steps to control the contents of these illegal substances.

As Ethan Nadelmann has pointed out, we would never allow liquor to be sold without the percentage of alcohol clearly marked on the bottle.[44] Similarly, we regulate the concentration of aspirin and all other over-the-counter drugs. Why shouldn't we do the same for heroin, cocaine and marijuana? - substances that are ingested by millions of Americans. The answer seems to be that our fear and dislike of drug use has become so pervasive, all humanitarian considerations - no matter how reasonable - are ignored.

Actually, with respect to opium, the Harrison Narcotics Act was a major step backwards. In 1906, Congress approved the Pure Food and Drug Act.[45] Amendments to that Act "required that the quantity of each drug be truly stated on the label, and that the drugs meet official standards of identity and purity."[46] But that concern for safety came to an abrupt end with the passage of the Harrison Narcotics Act. As a result, adulterated drugs, or drugs whose purity is dangerously high, are now being sold throughout the United States to both adults and children.

7. The Mixed Message of Tobacco and Alcohol

The case for the decriminalization of drugs becomes even stronger when illegal drugs are looked at in the context of legal drugs.

It is estimated that over 350,000 people will die this year from tobacco related diseases. Last year the number was equally large. And it will be again next year. Why do millions of people continue to engage in an activity which has been proven to cause cancer and heart disease? The answer is that smoking is more than just a bad habit. It's an addiction. Surgeon General C. Everett Koop earlier this year called nicotine as addictive as heroin and cocaine. And yet, with the exception of taxes and labeling, cigarettes are sold pretty much without restriction. They're cheap, widely available (including in vending machines) and widely advertised (except on television). They are not even classified as a drug, despite their highly addictive nature.

By every standard we apply to illicit drugs, tobacco should be a controlled substance. But it's not, and for good reason. Given that millions of people continue to smoke - many of whom would quit if they could - making cigarettes illegal would be an open invitation to a new black market. Criminal enterprises would break out all over the United States. The price of a pack of cigarettes would skyrocket. An illegal tobacco trade would completely overwhelm our criminal justice system. And the U.S. treasury would lose billions of dollars in taxes.

The certain occurrence of a costly and dangerous illegal tobacco trade (if tobacco was outlawed) is well understood by Congress, the Administration and the criminal justice community. No rationally thinking person would want to bring such a catastrophe down upon the United States - even if it would prevent some people from smoking. (And, not surprisingly, no opponent of drug decriminalization has suggested that we criminalize cigarettes.) Nevertheless, what is abundantly clear with respect to tobacco is painfully ignored with respect to drugs. But if we don't want to learn from what we can expect to happen in a world of illegal tobacco, we should at least be willing to learn from what we already know happened in a world of illegal alcohol.

Like tobacco, alcohol is also a drug that kills thousands of Americans every year. It plays a part in over half of all automobile fatalities; and is also frequently involved in suicides, non-automobile accidents, domestic disputes and crimes of violence. Millions of Americans are alcoholic, and alcohol costs the nation billions of dollars in health care and lost productivity. So why not ban alcohol? Because, as almost every American knows, we already tried that. Prohibition turned out to be one of the worst social experiments this country has ever undertaken.

I will not review the sorry history of Prohibition except to make two important points. The first is that in repealing Prohibition, we made significant mistakes that should not be repeated in the event that drug use is decriminalized. Specifically, when alcohol was again made legal in 1934, we made no significant effort to educate people as to its dangers. There were no (and still are no) "Just Say No" campaigns against alcohol. We allowed alcohol to be advertised and have associated it with happiness, success and social acceptability. We have also been far too lenient with drunk drivers.

The second point is that notwithstanding claims to the contrary by critics of decriminalization, there are marked parallels between the era of Prohibition and our current policy of making drugs illegal, and important lessons to be learned from our attempts to ban the use and sale of alcohol.

During Prohibition, the government tried to keep alcohol out of the hands of millions of people who refused to give it up. As a result, our cities were overrun by criminal syndicates enriching themselves with the profits of bootleg liquor and terrorizing anyone who got in their way. We then looked to the criminal justice system to solve the crime problems that Prohibition created. But the criminal justice system - outmanned, outgunned and often corrupted by enormous black market profits - was incapable of stopping the massive crime wave that Prohibition brought, just as it was incapable of stopping people from drinking.

Those opposed to decriminalization argue that "alcohol was different." The health effects may be different, although alcohol has actually been shown to be more physically and psychologically damaging than many illegal drugs; but the devastating effects of a multi-billion dollar black market are the same.

In the ongoing debate about the decriminalization of drugs, there are two lessons to be learned from Prohibition. One is that the only language the drug criminals understand is money. Therefore, the way to put them out of business is to take away their profits. That is not surrender; that is a strategy which can win what, up until now, has been a losing war against drug traffickers.

The second lesson has to do with the way in which drugs should be made a public health responsibility. Unlike alcohol, where we went from Prohibition to encouraging alcohol consumption - leaving the public health system to deal with the consequences - any form of decriminalization must be accompanied by a reallocation of resources to education, treatment and prevention programs designed to keep non-users away from drugs and current users off drugs. Moreover, as I'll elaborate in the recommendations section, this program should apply to alcohol and tobacco as well.

As a person now publicly identified with the movement to reform our drug laws through the use of some form of decriminalization, I consider it very important to say that I am not soft on either drug use or drug dealers. I'm a soldier in the war against drugs. I spent years prosecuting and jailing drug traffickers, and had one of the highest rates of incarceration for drug convictions in the country. And if I were still State's Attorney, I would be enforcing the law as vigorously as ever. My experience as a prosecutor did not in any way alter my passionate dislike for drug dealers, it simply convinced me that the present system doesn't work and can't be made to work.

As State's Attorney, I was confronted daily with the victims of our drug crimes, who for the most part are ignored by the opponents of drug decriminalization. One of my most painful duties as State's Attorney was prosecuting drug dealers who injured and sometimes killed police officers. In Baltimore, as in so many other cities, our police officers and undercover agents serve with distinction and uncommon bravery. Their work is dangerous and needs to be highly commended. But that is no reason to ignore common sense. The end-game in the war on drugs is not less supply or more jails, or even the death penalty. It's less profit and less demand - and that will only come about through increased efforts at treatment and prevention.

During the Revolutionary War, the British insisted on wearing red coats and marching in formation. They looked very pretty. They also lost. A good general does not pursue a strategy in the face of overwhelming evidence of failure. Instead, a good general changes from a losing strategy to one that exploits his enemy's weaknesses while exposing his own troops to only as much danger as is required to win. The drug traffickers can be beaten and the public health of the United States can be improved if we're willing to substitute common sense for rhetoric, myth and blind persistence.

Recommendations

Congress, in order to reduce the black market in illegal drugs, should begin taking incremental steps in the direction of making drugs less of a criminal justice responsibility and more of a public health responsibility.

A. **RECOMMENDATION:** Expand the role of the public health system in the treatment and prevention of drug abuse.

  1. United States drug policies and practices should be revised to ensure that no narcotics addict need get his or her drug from the "black market".

    a. Methadone maintenance should be expanded so that, under medical auspices, every narcotics addict who applies for treatment can receive it.

    b. Other forms of narcotics maintenance, including cocaine and heroin maintenance, should be made available, along with methadone maintenance, under medical auspices.

    It will be up to the physician to determine whether the person requesting maintenance is an addict. Drugs will not be dispensed to non-users.

    c. End the requirement that persons be addicted for at least one year before being eligible to enter a methadone treatment program.

2. Ban all advertising of drugs including alcohol and tobacco.
3. End government restrictions on research targeted to the potential medical uses of drugs.
4. Allow cancer patients to use Schedule I drugs for intractable pain.
5. Institute a clean needle exchange program as a way to reduce the spread of AIDS.
6. The federal government should lead a coordinated approach to adolescent drug education.
7. Develop community based programs designed to reach at-risk youths. These would include education, employment and mentor programs.

B. **RECOMMENDATION:** Redefine the role of the criminal justice system in the fight against drugs.

1. Establish a high level commission to study the potential impact of decriminalization with particular emphasis on developing substance control policies based upon the relative potential for harm which a drug possesses. The commission should also be responsible for determining if there would be a national standard for decriminalization and what role the states will play.

2. Immediately eliminate criminal penalties for simple possession of marijuana. Revise all other criminal statutes on drugs in accordance with the findings of the commission concerning the relative harm of drugs.
3. Limit drug testing to pre-employment exams affecting the health and safety of others, or when an employer has a reasonable suspicion of impairment, or as a monitoring service during a comprehensive rehabilitation and treatment program.
4. Increase the penalties for driving while impaired.
5. Impose mandatory jail terms on those who finance the importation and/or distribution of illicit drugs.
6. Adopt legislation to make it a crime to sell to children any drug that possesses the potential for serious bodily harm to the health of children (except drugs prescribed for medical use by physicians). Such legislation would include cigarettes and alcohol as well as those drugs currently deemed illicit.
7. Recommendations A(1)(a) and (b) and B(2) should not have to await the findings of the Commission and should be implemented immediately.

NOTES

[1] Editorial Comment, American Magazine (November 1915): 799-800 cited in The Consumers Union Report, Licit & Illicit Drugs, ed. Edward M. Brecher (1972), p. 50.

[2] Edward M. Brecher, "Drug Laws and Drug Law Enforcement: A Review and Evaluation Based on 111 years of Experience", in Perspective on Drug Use in the United States ed. by Bernard Segal published by Haworth Press, N.Y. (1986).

[3] American Medical Association, Report NNN of the Board of Trustees - Drug Abuse in the United States: A Policy Report, (1988), p. 2.

[4] Ibid.

[5] Cited in Washington Spectator Vol 14, No. 14 (Aug. 1, 1988).

[6] August Vollmer, The Police and Modern Society, (Berkeley, 1936), pp. 117-118, cited in Brecher et al., pp. 52-53.

[7] Brecher et al. (1972), p. 3.

[8] Brecher (1986), p. 3.

[9] Ibid., p.5.

[10] James A. Inciardi, *The War on Drugs: Heroin, Cocaine, Crime and Public Policy*, Mayfield Publishing Company (1986), p. 14.

[11] Ibid.

[12] Public Law No. 223, 63rd Cong. approved December 17, 1914.

[13] *Webb v. U.S.*, 249 U.S. 280 (1922).

[14] Inciardi (1986), p. 15.

[15] *American Magazine* cited in Brecher et at. (1972), p.50.

[16] Report NNN (1988), p. 9.

[17] Brecher et al. (1972).

[18] National Institute of Drug Abuse, cited in *Washington Spectator*, Vol 14, No. 14 (August 1, 1988).

[19] Testimony of Linda Lewis of the Alcohol, Drug Abuse and Mental Health Administration before The House of Representatives Select Committee on Narcotics Abuse and Control, (May, 1988).

[20] U.S. Justice Department, "Report to the Nation on Crime", (March 1988):51.

[21] Inciardi (1988), p. 126.

[22] Ibid., p. 119.

[23] Ibid.

[24] "Crime in Baltimore", prepared by Coordinating Council on Criminal Justice (1988), p. 12.

[25] Unpublished data from the Maryland Drug and Alcohol Abuse Administration, 9 September 1988.

[26] Ibid.

[27] Ethan A. Nadelmann, "The Case for Legalization", in The Public Interest (Summer 1988), p. 17.

[28] Ethan A. Nadelmann, "Shooting Up", in The New Republic, (June 13, 1988), p. 17.

[29] Unpublished data from the Baltimore City Police Department, Drug Enforcement Unit, September 1988.

[30] Nadelmann, "The Case For Legalization", p. 16.

[31] Ibid, p. 15.

[32] Ibid.

[33] AMA Report NNN (1988), p. 7.

[34] Ibid.

[35] Brecher (1986), p. 9.

[36] Paul Eddy, Hugo Sabogal and Walden, The Cocaine Wars, W.W. Norton Company, (1988).

[37] Ibid., p. 48.

[38] Ibid.

[39] Ibid., p. 49.

[40] Maryland Department of Health and Mental Hygiene Addictions Service Administration, "1986-87 Survey of Substance Abuse Among Maryland Adolescents", Table 12 (November 1, 1987), p. 16.

[41] Nadelmann, "The Case For Legalization", p. 7.

[42] Cited in Brecher et al. (1972), p. 96.

[43] Nadelmann, "The Case For Legalization", p. 8.

[44] Ibid., p. 20.

[45] Public Law No. 383, 59th Cong. approved June 30, 1906.

[46] Brecher et al. (1972), p. 47.

TESTIMONY

OF THE

HONORABLE MARION BARRY, JR.

MAYOR

OF THE

DISTRICT OF COLUMBIA

ON

DRUG ABUSE ISSUES AND PROBLEMS

BEFORE THE

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

U.S. HOUSE OF REPRESENTATIVES

SEPTEMBER 29, 1988

MR. CHAIRMAN, AND MEMBERS OF THE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL, I AM PLEASED TO HAVE THIS OPPORTUNITY TO PRESENT TESTIMONY ON THE NATURE OF THE DRUG PROBLEM AND APPROACHES THAT SHOULD BE TAKEN TO ELIMINATE THE EVILS OF ILLICIT DRUGS FROM OUR SOCIETY.

DRUGS ARE THE NUMBER ONE THREAT TO THE STABILITY AND GROWTH OF OUR NATION. WITH APPROXIMATELY 37 MILLION AMERICANS HAVING USED ILLEGAL DRUGS LAST YEAR, THE PERVASIVENESS OF THIS PROBLEM THAT AFFECTS ALL RACES AND CLASSES OF PEOPLE; ALL PARTS OF THE COUNTRY, AND ALL AGE GROUPS, INCLUDING THE UNBORN CHILD, REQUIRES US TO LEAVE NO STONE UNTURNED IN OUR QUEST FOR SOLUTIONS.

PERHAPS THE MOST HARMFUL EFFECT OF THE DRUG PROBLEM IS MANIFESTED IN THE COMMISSION OF CRIMES ASSOCIATED WITH DRUG USE AND SALES. DRUGS, FOR THE MOST PART, ARE CURRENTLY DRIVING THE CRIMINAL JUSTICE SYSTEM BOTH IN THE DISTRICT AND THE NATION. APPROXIMATELY 80 PERCENT OF RECENTLY SENTENCED PRISONERS IN THE DISTRICT WERE CONVICTED OF DRUG VIOLATIONS OR VIOLENT CRIMES ASSOCIATED WITH THE DRUG TRADE.

THE FEDERAL GOVERNMENT ATTRIBUTES OVER ONE THIRD OF RECENTLY CONVICTED PRISONERS TO DRUG RELATED OFFENSES. THE COSTS ASSOCIATED WITH THE DRUG-RELATED CRIMES ARE PHENOMENAL. SPENDING FOR LAW ENFORCEMENT, PROSECUTIONS AND CORRECTIONS HAVE SKY ROCKETED, YET THE PROBLEM WORSENS.

FURTHERMORE, CITIZENS HAVE BECOME INCREASINGLY MORE FRUSTRATED AS THEY EXPERIENCE NEIGHBORHOODS OVERRUN BY DRUG PUSHERS AND WATCH THEIR YOUTH SUCCUMB TO THE RAVAGES OF DRUG ABUSE.

WHAT HAS BEEN WOEFULLY ABSENT IN THE STRUGGLE TO ERADICATE DRUGS IS NATIONAL LEADERSHIP. TO SAY, "JUST SAY NO" IS NOT ENOUGH, PARTICULARLY WHEN FEDERAL SUPPORT FOR HUMAN SERVICES, HOUSING, EMPLOYMENT TRAINING, EDUCATION AND ENTITLEMENT PROGRAMS HAS DIMINISHED OVER THE PAST SEVERAL YEARS. UNDER CURRENT NATIONAL POLICIES, WE SELL MILITARY ARMS AND OFFER OTHER ASSISTANCE TO SOME OF THE LARGEST IMPORTERS OF ILLEGAL DRUGS TO THE UNITED STATES. IT IS ESTIMATED THAT 75 PERCENT OF THE COCAINE IN THE UNITED STAATES COMES FROM COLUMBIA AND THE PROBLEMS STEMMING FROM THE IMPORTATION

OF COCAINE FROM PANAMA HAVE BEEN WELL DOCUMENTED. YET, WE DEVELOP POLICIES AND SANCTIONS THAT HAVE THE SALUTARY EFFECT OF PUNISHING THE CONSUMER OF ILLEGAL DRUGS WHEN WE HAVE NOT RIGOROUSLY PURSUED AVAILABLE OPTIONS FOR REDUCING THE SUPPLY OF ILLEGAL DRUGS. I SUBMIT THAT A DRAMATIC SHIFT IN NATIONAL POLICIES THAT EMPHASIZES REDUCTION OF THE SUPPLY OF DRUGS ENTERING THE COUNTRY IS A PRIMARY STEP IN REALIZING ANY SUCCESS IN FIGHTING THIS PERVASIVE PROBLEM.

EFFORTS AIMED AT ERADICATING THE DRUG PROBLEM OFTEN ARE REFERRED TO AS THE "WAR ON DRUGS". THUS FAR, NATIONAL EFFORTS SHOULD ONLY BE REALISTICALLY REFERRED TO AS A "SKIRMISH" AS THE RESOURCES NEEDED FOR A WAR HAVE NOT BEEN MADE AVAILABLE. IN FISCAL YEAR 1988, BUDGET AUTHORITY FOR DEFENSE SPENDING EXCEEDS $291 BILLION IN COMPARISON WITH A LITTLE OVER $21 BILLION IN BUDGET AUTHORITY FOR FEDERAL LAW ENFORCEMENT EFFORTS. EVEN IF WE FACTOR IN 1988 BUDGET AUTHORITY FOR MANY OF THE HUMAN SUPPORT PROGRAMS THAT ARE VIEWED AS INSTRUMENTAL

IN PREVENTING DRUG ABUSE, SUCH AS HEALTH AND HUMAN SERVICES ($176.7 BILLION), HOUSING AND URBAN DEVELOPMENT ($15.4 BILLION), AND EDUCATION ($20.3 BILLION), THE TOTAL COMBINED BUDGETS ($212.4 BILLION) DO NOT MATCH THE AMOUNT AUTHORIZED FOR DEFENSE SPENDING. CLEARLY, A REORDERING OF OUR NATIONAL PRIORITIES IS NEEDED IF WE EXPECT TO MAKE A NOTICEABLE DENT IN THE DRUG MARKET.

I HAVE SPENT NUMEROUS HOURS THINKING ABOUT BOTH THE CAUSES AND POSSIBLE SOLUTIONS TO THE DRUG PROBLEM. WHILE I DO NOT HAVE DEFINITIVE ANSWERS, I AM CONVINCED THAT WE HAVE NOT DISSECTED THE ISSUE INTO SEPARATE COMPONENTS THAT WILL MAKE THE OVERALL PROBLEM MORE AMENABLE TO ANALYSIS. WE TEND TO TAKE A HOLISTIC VIEW OF DRUGS AND CRIME, BUT AS I SEE IT, THERE ARE FIVE DISTINCT CATEGORIES OF PEOPLE FOR WHOM TREATMENT, LAW ENFORCEMENT AND PREVENTION POLICIES MUST BE DIRECTED.

FIRST, THE INDIVIDUAL WHO HAS A PHYSIOLOGICAL AND/OR PSYCHOLOGICAL ADDICTION TO DRUGS SHOULD BE VIEWED AS A MEDICAL PROBLEM AND TREATED AS SUCH. AS LONG AS CRIMINAL LAWS ARE NOT VIOLATED IN ACQUISITION OF THE FUNDS TO PURCHASE ILLEGAL DRUGS, WE SHOULD NOT USE SCARCE CRIMINAL JUSTICE RESOURCES IN PURSUIT OF THIS TYPE OF INDIVIDUAL.

SECOND, THERE IS A CATEGORY OF OFFENDER WHO INITIALLY ONLY USED DRUGS BUT RESORTED TO CRIMINAL ACTIVITY TO OBTAIN MONEY NEEDED TO PURCHASE THE DRUGS FOR WHICH A PHYSICAL DEPENDENCE HAD DEVELOPED. THIS TYPE OF PERSON'S GREATEST NEED IS FOR MEDICAL INTERVENTION, ACCOMPANIED BY CLOSE MONITORING TO ASSURE THAT PRESCRIBED TREATMENT ROUTINES ARE BEING FOLLOWED. ALSO, FOR THIS OFFENDER, NON-INCARCERATIVE SANCTIONS THAT ALLOW FOR RESTITUTION SHOULD BE EXPLORED WHEN THE OFFENSES DO NOT INVOLVE VIOLENCE.

THE THIRD CATEGORY INVOLVES THE MID-LEVEL STREET DEALER WHO, WHILE NOT ADDICTED, OCCASIONALLY USES DRUGS. STIFF CRIMINAL PENALTIES

SHOULD BE IMPOSED FOR THIS TYPE OF OFFENDER WITH AN EMPHASIS ON BREAKING UP THE CADRE OF SELLERS AND BUYERS WITH WHOM HE/SHE INTERACTS BECAUSE RECENT TRENDS SUGGEST A SHIFT TOWARDS MORE VIOLENCE ASSOCIATED WITH THE DRUG TRADE. PREVIOUSLY, DRUG USE AND SALES WERE CLOSELY RELATED TO THE COMMISSION OF PROPERTY CRIMES SUCH AS BURGLARY AND LARCENY. CURRENTLY, DRUG TURF BATTLES RAGE BECAUSE OF THE TREMENDOUS AMOUNT OF PROFIT REALIZED FROM DRUG SALES AND THE COROLLARY INCREASE IN HOMICIDES AND ASSAULTS HAS TRANSFORMED STREETS IN MANY URBAN AREAS TO ASPHALT BATTLE GROUNDS. MANY OF THESE VIOLENT ACTS INVOLVE THE USE OF FIREARMS. THE DISTRICT OF COLUMBIA HAS VERY STRICT FIREARMS REGISTRATION LEGISLATION BUT UNTIL NEIGHBORING STATES AND THE NATIONAL GOVERNMENT IMPLEMENT POLICIES AND LAWS GOVERNING WIDESPREAD PURCHASE AND POSSESSION OF FIREARMS, IT WILL BE DIFFICULT TO STEM THE VIOLENCE ASSOCIATED WITH ILLEGAL DRUG SALES.

THE FOURTH CATEGORY IS THE OBJECT OF MY EXTREME IRE AND I LABEL THEM, "INTERNATIONAL DRUG THUGS". THESE ARE THE HIGH LEVEL ENTREPRENEURS WHO IMPORT THESE KILLER SUBSTANCES INTO OUR COUNTRY AND MAKE MILLIONS FROM THEIR SALE WHILE OPERATING UNDER A CLOAK OF RESPECTABILITY. THESE ARE INDIVIDUALS FOR WHOM A WELL COORDINATED, COMPREHENSIVE FEDERAL POLICY IS MOST NEEDED IF WE ARE TO REALIZE ANY MEANINGFUL IMPACT ON THE UNLIMITED SUPPLY OF DRUGS COMING INTO OUR COUNTRY. TO DESTROY THE SUCCESSFUL OPERATIONS OF THESE "INTERNATIONAL DRUG THUGS" MANDATES STRONG LEADERSHIP AND CENTRAL OVERSIGHT AT THE NATIONAL LEVEL. BANKS AND OTHER FINANCIAL INSTITUTIONS MUST BE HELD ACCOUNTABLE FOR THEIR TACIT COOPERATION WITH THESE CROOKS BY HELPING THEM LAUNDER MONEY AND OTHER ASSETS OBTAINED THROUGH THEIR ILLEGAL ACTIVITIES. ADDITIONALLY, MEASURES MUST BE TAKEN BY THE FEDERAL GOVERNMENT TO MAKE IT MORE DIFFICULT FOR ILLEGALLY OBTAINED FUNDS TO BE SENT OUT OF THE COUNTRY AND USED AS COLLATERAL TO FURTHER SUPPORT HIGHLY SOPHISTICATED INTERNATIONAL DRUG RINGS. THIS LEVEL IS WHERE THE PROFIT MOTIVE IS STRONGEST AND WE MUST EXERCISE DIFFFERENT STRATEGIES FOR TAKING THE PROFIT OUT OF DRUG DEALING.

FURTHERMORE, ONCE THESE "INTERNATIONAL DRUG THUGS" ARE APPREHENDED AND CONVICTED, WE MUST TAKE STRIDENT STEPS TO ENSURE THAT THEY DO NOT CONTINUE TO DIRECT THEIR OPERATIONS FROM PRISON. THEY SHOULD BE BARRED FROM HAVING CONTACT WITH THEIR FORMER ACCOMPLLICES WHO OFTEN CONTINUE TO MANAGE THE ILLEGAL OPERATIONS.

ADMINISTRATIVE AND BUDGETARY OVERSIGHT IS FRAGMENTED FOR DRUG CONTROL FUNCTIONS. CURRENTLY, THREE SEPARATE DEPARTMENTS OF THE U.S. GOVERNMENT ARE RESPONSIBLE FOR FEDERAL INTERDICTION; TREASURY, TRANSPORATION AND JUSTICE. FURTHERMORE, THE AGENCIES WITHIN THOSE DEPARTMENTS, CUSTOMS, COAST GUARD AND DRUG ENFORCEMENT ADMINISTRATION (DEA), HAVE DIFFERENT PROGRAMS, GOALS AND PRIORITIES. ALSO, THERE IS NO UNIFIED BUDGET AND VERY LITTLE FACTUAL INFORMATION ABOUT THE EFFECTIVENESS OF ANTI-DRUG PROGRAMS.

THE ISSUES OF PROGRAM EFFECTIVENESS LEADS ME TO THE FIFTH CATEGORY THAT REQUIRES OUR ATTENTION -- THE YOUNG PEOPLE WHO SELL DRUGS BUT DO NOT USE THEM. THEY CURRENTLY POSE ONE OF THE GREATEST CHALLENGES TO LOCAL OFFICIALS WHO ARE GRAPPLING WITH WAYS TO SHAPE

ATTITUDES AND CHANGE VALUES FROM THE MATERIALISTIC FOCUS OF YOUTH WHO SEE SELLING DRUGS AS THE KEY TO MANHOOD, WEALTH AND SUCCESS.

OF COURSE, THESE YOUTH MUST BE REMOVED FROM THE STREETS AND PREVENTED FROM ENGAGING IN ILLEGAL ACTIVITIES. HOWEVER, THE BIGGER QUESTION IS "HOW DO WE DISCOURAGE DRUG USE AND SALES AND PROMOTE THE ADOPTION OF VALUES THAT EMBRACE THE WORK ETHIC, EDUCATIONAL ACHIEVEMENT AND SOCIAL ENLIGHTMENT?"

WE KNOW THAT THE USE OF COCAINE, HEROIN, AND MARIJUANA ALL HAVE DELETERIOUS EFFECTS ON THE BODY. WE KNOW FULL WELL THE DAMAGE CREATED BY DRUG USAGE ON THE UNBORN CHILD; BABIES BORN WITH LOW BIRTH WEIGHTS TO MOTHERS WHO USED DRUGS DURING PREGNANCY; THE POTENTIAL FOR TEMPORARY AND PERMANENT DAMAGE TO THE BRAIN; AND, IMPAIRED MEMORY, PERCEPTION AND JUDGEMENT.

WE ALSO KNOW THAT MANY DRUG USERS HAVE PROBLEMS WITH ALCOHOLISM: 80% OF COCAINE ADDICTS AT PRESENT BECOME ALCOHOLIC AND IT IS ESTIMATED THAT 60% OF NARCOTICS ABUSERS DEVELOP ALCOHOL DEPENDENCY PROBLEMS.

FURTHERMORE, WHILE ABOUT 10% OF THE NATION'S DRINKERS ARE ALCOHOLIC, 75% MORE OF ALL REGULAR ILLICIT DRUG USERS BECOME ADDICTED.

DUE TO THE SEVERE HEALTH, SOCIAL, PSYCHOLOGICAL AND ECONOMIC PROBLEMS THAT ACCOMPANY DRUG ABUSE, THE DISTRICT GOVERNMENT HAS ALSO INCREASED RESOURCES AND SERVICES FOR PERSONS WHO ARE NOT DIRECTLY INVOLVED IN THE CRIMINAL JUSTICE SYSTEM. IN 1986, THE DISTRICT'S EXPENDITURES FOR DRUG PREVENTION TOTALLED $1,554,000. PLANNED EXPENDITURES FOR FY 1988 ARE $2,313,000, A FORTY-NINE PERCENT INCREASE. IN ADDITION, I HAVE LAUNCHED A NEW DELINQUENCY PREVENTION PROGRAM CALLED "INVEST IN OUR FUTURE" WHICH IS A BROAD BASED APPROACH TO PREVENT YOUTH FROM BECOMING INVOLVED IN THE JUVENILE JUSTICE SYSTEM.

THE ALCOHOL DRUG ABUSE SERVICES ADMINISTRATION (ADASA) PROVIDES PRIMARY AND COMMUNITY BASED SUBSTANCE ABUSE PREVENTION PROGRAMS. ADASA AND THE D.C. PUBLIC SCHOOLS WORK TOGETHER IN PROVIDING PRIMARY

SUBSTANCE ABUSE PREVENTION PROGRAMS. THE D.C. PUBLIC SCHOOLS HAVE ALSO USED A $500,000 GRANT UNDER THE ANTI-DRUG ACT TO ESTABLISH A SUSTANCE ABUSE OFFICE IN THE D.C. PUBLIC SCHOOLS. THE DISTRICT'S DRUG TREATMENT PROGRAMS HAVE GROWN DRAMATICALLY. IN FY 1986, EXPENDITURES FOR DRUG TREATMENT TOTALLED $10,429,000 BUT IN FY 1989, THE DISTRICT PLANS TO SPEND $19,255,000, AN 84% INCREASE!

THERE IS NOW ACCESSIBILITY TO TREATMENT FOR LESS THAN 10 PERCENT OF THOSE WHO NEED IT IN THE DISTRICT. THIS IS CONSISTENT WITH SIMILAR NATIONAL FIGURES. BUT TO PROVIDE TREATMENT TO THAT SMALL FRACTION OF THOSE IN NEED COSTS MORE THAN $27 MILLION EACH YEAR IN THE DISTRICT. OTHER COSTS NOT CONSIDERED ARE IN DRUG-RELATED AUTOMOBILE ACCIDENTS, REDUCED PRODUCTIVITY, LOST EMPLOYMENT, AND DRUG RELATED DEATHS, NOT TO MENTION THE HEALTH CARE COSTS CITED EARLIER.

NO COST CAN BE CALCULATED FOR THE GRIEF AND STRESS UPON FAMILY AND LOVED ONES OF THOSE WHO ABUSE DRUGS. DRUG ABUSE IS A DISEASE THAT INFECTS THOSE DIRECTLY INVOLVED AND ADVERSELY IMPACTS THOSE CLOSE TO THE USER.

IN ORDER TO REALLY COMBAT THESE SERIOUS PROBLEMS, THE CONGRESS MUST INSIST UPON AND FUND MAJOR RESEARCH PROGRAMS TO DETERMINE WHAT IS NEEDED FOR LONG TERM TREATMENT OF COCAINE AND PCP ADDICTION. WE DON'T KNOW ENOUGH ABOUT HOW TO TREAT PERSONS ADDICTED TO EITHER OF THESE DRUGS. NATIONAL LEADERS MUST IMPLORE THE BEST MEDICAL, PSYCHIATRIC AND SOCIAL POLICY EXPERTS OF OUR ERA TO EXAMINE THIS ISSUE AND DEVELOP TREATMENT PROTOCOLS.

I AM DEEPLY CONCERNED ABOUT THE ACTIONS RECENTLY TAKEN BY THE U.S. HOUSE OF REPRESENTATIVES WITH REGARD TO THE "OMNIBUS DRUG INITIATIVE ACT OF 1988" (H.R. 5210). THE TONE OF THE DEBATE AND THE VOTES ON FLOOR AMENDMENTS IS ONE WHICH WILL NOT ELIMINATE DRUG ABUSE IN THIS NATION. LEGAL SANCTIONS SUCH AS THE DEATH PENALTY, DENIAL OF

CERTAIN FEDERAL BENEFITS, CHANGES IN THE EXCLUSIONARY RULE TO PERMIT INTRODUCTION OF EVIDENCE IN FEDERAL CRIMINAL CASES, AND STRONG PENALTIES FOR SIMPLE POSSESSION WILL NOT DETER DRUG ABUSE IN THIS COUNTRY. MOST OF THESE AMENDMENTS SEEK TO PUNISH THE USER AND NOT THE TYPE OF LARGE DRUG DEALERS I SPOKE OF EARLIER. WE CANNOT LEGISLATE AWAY THE MEDICAL AND PSYCHOLOGICAL PROBLEM OF DRUG ADDICTION.

OBVIOUSLY, THERE IS NO SIMPLE ANSWER, BUT I FIRMLY BELIEVE THAT THE WAR CAN BE WON. TO DATE, WE HAVE ADDRESSED OUR SUBSTANCE ABUSE EFFORTS AS THOUGH WE WERE PREPARING FOR A BATTLE NOT A WAR. WE HAVE USED OBSELETE TECHNIQUES AND TECHNOLOGY. WE HAVE USED WORLD WAR II STRATEGY FOR A VIETNAM TYPE WAR. WE CAN DEVELOP "STAR WARS" TECHNOLOGY TO PROTECT OUR BORDERS. IF WE CAN DETERMINE WHERE UNDERGROUND MISSILES ARE STORED FROM SATELLITES MILLIONS OF MILES IN OUTER SPACE, SOMETHING SIMILAR CAN PERHAPS BE DESIGNED TO DETECT THE CULTIVATION OF DRUGS IN OTHER COUNTRIES. THIS CHALLENGE IS NOT TOO GREAT FOR A COUNTRY WITH THE GREATEST SCIENTIFIC MINDS IN THE WORLD.

LET US BEGIN BY RECOGNIZING THAT MAY FRONTS MUST BE ATTACKED SIMULTANEOUSLY; A COMPREHENSIVE MULTILEVEL APPROACH MUST BE USED. THE FEDERAL GOVERNMENT MUST TAKE THE LEAD, BUT EVERY STATE, EVERY CITY, EVERY COMMUNITY, AND EVERY CITIZEN, MUST PLAY A PART.

STATEMENT PREPARED BY THE HONORABLE DONALD C. MASTER, MAYOR OF CHARLES TOWN, WEST VIRGINIA, FOR PRESENTATION TO THE SELECT COMMITTEE OF NARCOTICS ABUSE AND CONTROL, UNITED STATES HOUSE OF REPRESENTATIVES, WASHINGTON, D.C., SEPTEMBER 29, 1988.

The rapid increase in drugs abuse recorded in the United States during the closing quarter of the twentieth century has become one of our country's most serious social problems as drug producers have been drawn to the United States as the world's most lucrative market for the sale of their illicit and dangerous products.

Despite the substantial number of bills pending in Congress on various phases of proposed drug control, there is a certain amount of skepticism on the part of many of our citizens that what will result will fall far short of what is needed to correct the situation. The feeling among a great many people is that "not enough is being done to correct the situation". I am among those who are convinced that we must come up with a wide ranging national strategy that will bring forth a strongly worded, strongly enforced, national anti-drug program including, if necessary, the legalization of drugs. We expect more than mere theatrics, media aimed rhetoric, and meringue type legislation from our leaders in Washington.

The tentacles of drug distribution in the United States have spread from coast to coast. Until recently, however, such distribution primarily was confined to our larger metropolitan centers. Unfortunately, our smaller communities no longer are immune to this danger. As pressure against drug sales increases in our larger cities pushers now shift a part of their operations to smaller, near-by communities where police forces are weaker and have less experience in combatting drugs distribution.

Let me direct your attention to Charles Town, West Virginia, a small community of 2,800 people, located 90 minutes driving time from our nation's capital. George Washington surveyed the area, and the town is named after his brother, Charles. The ninth generation of Washingtons is living in this city of tree lined streets and lovely, historic homes and, for the past 21 years, I have had the honor of serving as its mayor.

Two years ago, when we were celebrating the 200th anniversary of the founding of our city, drug pushers were beginning to sell their illegal products on our streets, tapping on our automobile windows as we slowed for stop signs.

On Saturday afternoon, April 9, 1988, a collection of 77 federal, state and county law enforcement authorities joined our eight man police force and officers from nearby cooperating communities and converged on an area identified by the press as "The Strip". In the ensuing activities five persons were hospitalized, one suffering from gun shot wounds, a patrol car was badly damaged, and individuals suspected of selling drugs were bundled up and bussed to the federal court in nearby Martinsburg where they were arraigned before a federal magistrate. On Saturday and the next few days following the raid a total of 44 persons were taken into custody. Only five spent a night in jail, and drugs were again being sold on the street by Sunday afternoon.

The raid was a traumatic experience for our small city. It was like looking at the drug problem through a microscope with every issue magnified because, in one way or another, it affected a larger percentage of the city's population than would have been the case if it had happened in Washington, D.C. or Baltimore. To our citizens it must have rivaled, in intensity of feeling, a somewhat similar type of operation that occurred in Charles Town 129 years earlier, when local militiamen hastily assembled and rode to Harpers Ferry to participate in the arrest of another law breaker, abolitionist John Brown.

Plans for the drug raid had been in the making for 24 months, and growing tired of the waiting I wrote to Governor Arch Moore pleading for him to assign top priority to the city's request for corrective action. Governor Moore responded promptly and effectively, and state and federal officials arrived in Charles Town to finalize the raid.

The waiting period of 24 months saw a blanket of anxiety settle over the little community as the drug situation steadily worsened, with our citizens calling for corrective action. For those few local officials who knew of the forthcoming raid it was a difficult time, as we increasingly became the target for our "inactivity". Incidentally, the raid was originally scheduled for the month of June, 1988, but was pushed forward to April 9 when it was learned that ABC was going to televise a program "A Plague Upon the Land" that would depict, among other scenes, the drug problem in Charles Town on April 10, 1988.

The outcome of the April 9 raid is that, to date, 32 trials have been held, with 31 convictions. The average prison term was for 5 years. It has been estimated that the raid cost approximately $500,000. Luckily for Charles Town most of the cost was born by the state of West Virginia. Charles Town's entire general fund budget for the fiscal year 1987-1988 is only $684,000.

The manner in which the Charles Town drug raid was planned and placed into operation, the ensuing results of the raid, and the physical and emotional effects it had on our citizens, are reflective of similar drug problems that are being experienced in other small communities throughout the United States. Drug sellers are finding good markets for the distribution of their wares in small cities because the risks of detection are less than in larger cities, and because, generally, there are no disputes over territorial rights. Drug dealers are finding that customers from the big cities are willing to drive the extra miles if by so doing they are reducing the chances of being caught. So, today every small town in the United States has its own real or potential "Cocaine Alley".

It will be noted that I have refrained from attempting to give specific answers to the questions raised by Chairman Rangel in his letter of July 29 to invitees. I do not presume to have the expertise required to provide knowledgeable answers to his questions. However, I would like to make some modest suggestions as to what should be included in a national anti-drug program. In my opinion, such a program should include eight points. Many of these points are either in operation or are under consideration by Congress, and I hope you will excuse this repetition from a small town mayor.

1. We should continue our international cooperation with the United Nations, regional organizations, and major drug producing countries to slow the quantity of illicit drugs entering world trade channels. If we can't achieve workable agreements with major producing countries we should consider stopping military and economic aid to these countries.

2. We should increase our own domestic efforts to curtail the volume of drugs entering the United States. Without legalizing the use of hard drugs in our country we cannot hope to stop all drugs from coming into the United States, but we should be able, by other means, to reduce the volume of drugs successfully crossing our borders. The possible use of our military forces in the prevention of drug smuggling into the United States and for other anti-drug activities presents some problems. Apparently the Pentagon opposes this, but on the wrong assumption, that the military couldn't do the job. The principal reason for not using the military during peace times to assist in drug control is that it sets a precedent that may, in the long run, prove to be wrong, and we may well find ourselves using our armed forces to perform tasks never anticipated by the founders of our country. However, I would support the extended use of the Coast Guard and the National Guard in combatting drug smuggling.

3. The adoption of a more effective educational program against the use of drugs certainly should be an integral part of any national anti-drug program. Primarily, such a drug education program should continue to be aimed toward the young-the very young-to discourage them from experimenting with drugs, and to provide more information to parents, schools, community organizations, and professional staffs. The program should make available specific information on the dangers of drug usage and the value of better lifestyles.

4. There should be no lessening of police efforts to find and arrest those individuals engaged in drug usage and drug sales. Local police forces in smaller communities should be provided with general guidance information, special training when required, and instructions on how to obtain assistance from state and federal agencies when such help is needed.

5. Testing for drug usage should be required of individuals involved with public safety. This would include those concerned with air, land, and sea transportation of the general public and also those individuals serving in military, police and fire fighting units.

6. The treatment and rehabilitation of drug mis-users is as important as punishment and, indeed, the drug problem is as much a health problem as it is a crime problem. Drug users have the same rights to appropriate treatment as people with other health and social problems. I would prefer to have the federal government finance and operate this phase of the anti-drug program because I have a diminishing confidence in the effectiveness of federally financed state operated projects. One of the difficulties in implementing treatment and rehabilitation programs is that we are not confident we have the best ways and the best substances for treating drug misuse. Research activities should be conducted to achieve better results in these areas.

7. The criminal justice system in the United States is in danger of becoming yet another victim of our national drug problem. Prisons and jails are considerably overcrowded, primarily because of the great increase in the number of inmates incarcerated for drug and drug related problems. Court calendars are over filled, and pending cases have to be delayed or dismissed. In imposing sentences judges are being confronted with the seemingly conflicting factor of individual rights vs. the right of society for self-preservation.

We should re-examine our interpretations of the fourth amendment to our constitution. In the face of the intensity of drug mis-use in our country we should allow more and better searches of passenger luggage at international air, sea and land terminals and the search of student lockers in our schools. In general, we should grant the police the authority to search, without warrant, individuals, automobiles, airplanes, boats, buildings and homes wherever and whenever drug possession is suspected.

Sentences for drug use and drug trafficking should be more severe. First users should be fined and should be required to seek help. If convicted a second time they should be jailed. All persons convicted of transporting and/or selling drugs should be sent to prison. Those sentenced to five years or more should lose the right of parole. The maximum penalty for drug trafficking should be the death sentence.

However, lengthy sentences for drug trafficking are not enough to deter offenders. Drug traffickers should not be allowed to profit from their activities after they have been released. New legislation should be adopted that will make it easier for our courts and law enforcement officials to trace and to confiscate such profits. The profit motive is the leading incentive in drugs trafficking and it can be limited or eliminated in three ways: (1) by the imposition of larger fines as well as longer sentences, (2) by legally seizing the assets of such offenders, and (3) by going the full route by legalizing drugs.

8. I have left the issue of legalization of drugs to the last because I fully understand and appreciate that such a proposal is distasteful to many of my fellow citizens. Few of our political leaders are prepared in this, an election year, to openly advocate the legalization of drugs. Many are of the opinion that to adopt such a program would open the flood gates for greater addiction. Some of us will recall that a few years ago the United Kingdom introduced a system whereby their doctors openly and legally could prescribe heroin and the result was a significant increase in the addict population of that country. However, in fairness to our British friends, that program was discontinued, and the old method of continued heroin maintenance was replaced by a program using first injectable and later oral methadone under the supervision of a licensing system operated by the Home Office.

Another apparent reason why many Americans currently have little enthusiasm for the legalization of drugs is somewhat less definable. It is based on the feeling that the United States is losing its backbone and that legalization would be yet another step toward becoming a "Permissive Society". There is an uneasy feeling the "things aren't right and haven't been right for a long time". People point to the results of two questionable wars in Korea and in Vietnam, to the accumulation of the world's largest national debt and, closer to home, the decline in family cohesion, parental guidance, a disappointing educational systemand an apparent decline in the morality and ethics of many of our political and religious leaders. Our citizens are concerned over the increase of plea bargaining in our court rooms and at the humiliation we have experienced in our unsuccessful attempts to rescue our hostages in the Middle East, patrol Lebanon and oust Panamanian General Manuel Antonio Noriega. They feel that legalizing drugs would be another case of "copping out" because we haven't got the courage or the desire to produce a better solution for our national drug problem.

The legalization of hard drugs in the United States is not warranted at the present time. Such a program should be held in reserve in case our other efforts to control drug usage and drug trafficking prove unsuccessful. If and when we do elect to go with drug legalization then we would be faced with a lot of problems, including such basic issues as the designation of dispensing centers, the registration of addicts, and the application of a centralized computer system that would help make certain that neither the addicts or the dispensers would misuse the system. I have grave doubts about allowing all doctors to become dispensing agents.

It may be possible to legalize marijuana if such legalization is subject to certain restrictions and certain enforceable controls, with the main idea being to make such usage socially undesirable. A national educational program, such as that led by Dr. C. Everett Koop, Surgeon General of the United States, in fighting tobacco addiction, should be implemented. All in all, however, I have the feeling that the use of marijuana will diminish over the next few years. For the present, its "legalization" should be confined to its approval for authorized medical purposes.

Maybe the legalization of drugs is workable, maybe it is not. For the present, let's study the relative advantages and disadvantages of legalization to be effectively prepared for any possible emergencies. Legalization could, eventually, become our last alternative in our battle to save our society and our country from the ravages of our national drug problem. The problems are difficult, but not insurmountable. I am certain that if we put together the best minds of Washington, D.C. and Charles Town, West Virginia, we certainly will emerge victorious.

TESTIMONY OF
EDWARD I. KOCH, MAYOR OF THE CITY OF NEW YORK
BEFORE THE HOUSE SELECT COMMITTEE
ON NARCOTICS ABUSE AND CONTROL
SEPTEMBER 29, 1988
WASHINGTON, D.C.

GOOD MORNING CHAIRMAN RANGEL, CONGRESSMAN GILMAN AND DISTINGUISHED MEMBERS OF THE SELECT COMMITTEE. LET ME BEGIN BY CONGRATULATING YOU ALL ON LAST WEEK'S PASSAGE OF THE 1988 OMNIBUS DRUG BILL. IT IS LARGELY YOUR HANDIWORK AND YOU ARE TO BE COMMENDED.

I WOULD NORMALLY PREFACE MY REMARKS BY SAYING THAT I'M GLAD TO BE HERE, BUT TODAY THAT IS NOT THE CASE. GIVEN THE DEVASTATION THAT DRUGS HAVE WROUGHT ON OUR COMMUNITIES AND NATION, PARTICULARLY OVER THE LAST FEW YEARS, I FIND IT ASTOUNDING THAT I AM HERE TO DISCUSS A NOTION THAT SEEMS TO ME TO BE THE EQUIVALENT OF EXTINGUISHING A RAGING FIRE WITH NAPALM, - - A FIRE THAT AT THIS VERY MOMENT IS FRYING THE BRAINS OF THOUSANDS OF AMERICANS.

MR. CHAIRMAN, THIS COMMITTEE, ALONG WITH THE VERY ACTIVE SUPPORT OF THE VAST MAJORITY OF AMERICA'S MAYORS, HAS MADE VALIANT EFFORTS IN THE PAST FEW YEARS TO DEVISE WAYS TO COMBAT THE DRUG SCOURGE THAT CONTINUES TO TEAR AT OUR NATION. TODAY, A SMALL, SMALL, NUMBER IN THESE RANKS, ARE, UNWITTINGLY IMPEDING OUR PROGRESS BY SUGGESTING THAT WE WAVE THE WHITE FLAG IN THE WAR ON DRUGS AND SUCCUMB TO THE ENEMY. IS THEIR VISION FOR THE FUTURE OF THIS COUNTRY NOTHING BETTER THAN ONE OF ITS BECOMING A BANNANA REPUBLIC?! I HOPE NOT, BUT SURELY THAT IS WHERE THEIR PROPOSITION WOULD LEAD US.

I AM FAR FROM ALONE IN FEELING THIS WAY. THE SEPTEMBER 15TH NEW YORK TIMES REPORTED THAT AN ABC NEWS POLL FOUND THAT MORE THAN 90% OF THE AMERICAN PUBLIC REJECT DECRIMINALIZING ALL ILLICIT DRUGS. THEY ALSO BELIEVE, BY A 2 TO 1 RATIO, THAT THE LEGALIZATION OF DRUGS WOULD LEAD TO AN INCREASE IN CRIME.

AND YET, IN PART BECAUSE OF THE FRUSTRATION SOME HAVE HAD WITH THE DIFFICULT TASK OF ADDRESSING THE DRUG PROBLEM, THE IDEA OF LEGALIZATION HAS BEEN ELEVATED, UNDESERVEDLY, TO A PLACE WITHIN THE REALM OF DEBATABLE, IF NOT POTENTIAL, POLICY ALTERNATIVES. NOW THAT IT IS THERE, IT MAY IN FACT BE NECESSARY TO PUT THE QUESTION OF LEGALIZATION ON THE TABLE, BUT ONLY TO PUT IT TO REST, SO THAT WE CAN MOVE FORWARD WITH THE STRATEGIES THAT WILL HAVE AN IMPACT.

BEFORE I CONTINUE, LET ME CITE SOME STATISTICS WHICH REVEAL THE DIMENSION AND IMPACT OF THE DRUG PROBLEM.

THERE ARE OVER 500,000 HEROIN ABUSERS IN THIS COUNTRY AND SIX MILLION PEOPLE WHO HAVE A SERIOUS COCAINE OR CRACK ABUSE PROBLEM. EVEN MORE TROUBLING IS THE INCREASING NUMBERS OF OUR YOUTH WHO ARE ABUSING CERTAIN DRUGS. ALTHOUGH NO ONE KNOWS FOR CERTAIN THE NUMBER OF JUVENILES USING DRUGS, SURVEYS OF HIGH SCHOOL STUDENTS HAVE SHOWN DRAMATIC INCREASES IN THEIR USE OF COCAINE OVER THE LAST TEN YEARS.

THE DEVASTATING EFFECTS OF DRUG ABUSE AND THE DRUG TRAFFICKING THAT SUPPLIES THE ABUSERS WITH THEIR POISON ARE QUITE CLEAR. RELIABLE STUDIES HAVE CONCLUDED THAT DRUG ABUSE AND DRUG TRAFFICKERS ARE RESPONSIBLE FOR MUCH OF THE VIOLENT CRIME IN OUR NATION.

THESE ASSERTIONS ARE SUPPORTED BY DATA FROM THE NATIONAL INSTITUTE OF JUSTICE'S DRUG FORECASTING SURVEY WHICH RECENTLY SHOWED THAT IN NEW YORK CITY, 79% OF THE SURVEYED ARRESTEES TESTED POSITIVE FOR AT LEAST ONE DRUG (INCLUDING MARIJUANA), 63% TESTED POSITIVE FOR COCAINE, INCLUDING CRACK, AND 25% TESTED POSITIVE FOR HEROIN.

INDEED, THE NEW YORK CITY POLICE DEPARTMENT HAS ARRESTED ALMOST 150,000 PEOPLE FOR DRUG RELATED CRIME OVER THE LAST TWO YEARS, - - UP 17% FROM 1986 TO 1987 AND 11% IN THE FIRST FIVE MONTHS OF 1988. THIS DATA CLEARLY UNDERSCORES THE RELATIONSHIP BETWEEN DRUG ABUSE AND CRIME.

IT IS UNDENIABLE THAT, IF WE DO NOT REDUCE DRUG ABUSE, ITS RESULTING CRIME AND OTHER DESTRUCTIVE PHYSIOLOGICAL CONSEQUENCES WILL CONTINUE TO ESCALATE AND WILL RESULT IN A NATIONAL TRAGEDY OF MUCH GREATER PROPORTIONS THAN IT IS TODAY.

THE SUGGESTION THAT WE SHOULD LEGALIZE DRUGS IS THEREFORE ALL THE MORE SHOCKING. HOW WOULD LEGALIZATION REDUCE DRUG ABUSE AND ITS RESULTING DEVASTATION AND CRIME? LET'S ANALYZE THE LEGALIZATION ARGUMENTS.

TO START WITH, SOME WOULD HAVE US BELIEVE THAT THE LAWS AGAINST DRUG USE AND DRUG TRAFFICKING ARE PROHIBITIONS AGAINST A MANNER OF PERSONAL CONDUCT OR STYLE AND THAT THEY ARE THE IMPOSITION OF SOCIETY'S MORAL VALUES ON THE INDIVIDUAL. THIS IS JUST NOT THE CASE. RATHER, THEY ARE LAWS THAT PROHIBIT CONDUCT WHICH DESTROYS NOT ONLY THE INDIVIDUAL USERS, BUT THEIR FAMILIES, THE INNOCENT VICTIMS OF THEIR CRIMES AND THE VERY FOUNDATION OF A PRODUCTIVE SOCIETY.

THE PROPONENTS OF LEGALIZATION ARE WEAK ON THE SPECIFICS OF THE IMPLEMENTATION OF A POLICY OF "DRUGS FOR ALL". SOME SUGGEST THAT GOVERNMENT SHOULD PLAY A "BIG BROTHER" ROLE, PROVIDING FIXED DOSES TO ADDICTS, AND THEREBY LIMITING DRUG USE. THEIR LACK OF UNDERSTANDING OF DRUG ABUSE IS STARTLING, SINCE THERE IS NO SUCH THING AS A FIXED DOSE THAT WILL SATISFY A DRUG ADDICT'S APPETITE FOR GREATER AND GREATER QUANTITIES. ACCORDINGLY, THE BLACK-MARKET THAT LEGALIZERS SAY WILL BE ELIMINATED, WOULD, OF NECESSITY, EXIST TO PROVIDE AN ADDITIONAL AVENUE OF OBTAINING THAT WHICH IS NOT AVAILABLE FROM "LEGITIMATE" SOURCES.

PIGGY-BACKING ON THE ASSERTION THAT LEGALIZATION WILL ELIMINATE THE HIGH PROFIT MARGINS ON DRUG SALES AND THEREFORE THE BLACK MARKET, PROPONENTS SAY THAT CRIME ASSOCIATED WITH DRUG TRAFFICKING WILL DIMINISH ONCE DRUGS BECOME AN ACCEPTABLE COMMODITY. THEY IGNORE HISTORY AND THE FACTS.

CHEAP DRUGS WON'T REDUCE CRIME AND THEY NEVER HAVE.

IN FACT, GIVEN ENGLAND'S DESPERATE FAILURE TO RELIEVE ITS HEROIN ADDICTION PROBLEM THROUGH HEROIN DISTRIBUTION PROGRAMS DURING THE 1960s AND 1970s, THE OPPOSITE IS CLOSER TO THE TRUTH.

UNTIL 1970, HEROIN WAS FREELY PRESCRIBED IN BRITAIN BY PRIVATE DOCTORS. BUT OVER-PRESCRIPTION LED TO A DOUBLING OF THE ADDICTED POPULATION BETWEEN 1970 AND 1980. THEN IT TOOK OFF.

CHEAP HEROIN FROM PAKISTAN, WHICH SOLD FOR $5 A FIX ON THE STREET, BEGAN FLOODING THE BLACK MARKET. NOT ONLY WAS IT SUPER CHEAP, IT WAS MORE POTENT THAN WHAT THE GOVERNMENT WAS HANDING OUT AND CAME WITHOUT BUREAUCRATIC RESTRICTIONS. CHEAP, POTENT AND HASSLE FREE, THE NEW STREET HEROIN QUADRUPLED THE NUMBER OF ADDICTS IN FIVE YEARS. BY 1986 THE BRITISH HOME OFFICE ESTIMATED THAT THERE WERE 50,000 TO 60,000 HEROIN ADDICTS IN THE COUNTRY. SOME UNOFFICIAL ESTIMATES WERE THREE TIMES GREATER.

HOW WAS CRIME IN BRITAIN AFFECTED BY LEGALIZATION? IN ONE 1978 STUDY, 50% OF THE ADDICTS IN GOVERNMENT PROGRAMS WERE CONVICTED OF CRIMES IN THEIR FIRST YEAR OF PARTICIPATION. UNEMPLOYMENT AMONG ADDICTS REMAINED CHRONIC TOO, AS DID OTHER KINDS OF DRUG USE - - 84% OF THE ADDICTS REGISTERED WITH THE GOVERNMENT WERE FOUND TO USE OTHER ILLICIT DRUGS AS WELL. ALL TOLD, THE GOVERNMENT PROGRAM WAS A DISASTER.

ANOTHER FACET OF THE CRIME PROBLEM ASSOCIATED WITH DRUGS THAT IS FREQUENTLY OVERLOOKED IS THAT A NUMBER OF DRUGS, AND CRACK IN PARTICULAR, HAVE BEEN SHOWN TO HAVE BEHAVIORAL EFFECTS THAT RESULT IN VIOLENT CRIMINAL CONDUCT NOT LIMITED TO THEFT TO OBTAIN MONEY TO PURCHASE DRUGS. I DON'T THINK THAT WE WOULD BE TOO FAR FROM THE MARK BY ASSUMING THAT THE EMERGING "DESIGNER" DRUGS WOULD HAVE SIMILAR EFFECTS AS THE DRUG SELLERS SEARCH FOR A PRODUCT THAT GIVES QUICKER AND MORE INTENSE HIGHS. SHOULD THE GOVERNMENT DISTRIBUTE OR CONDONE THESE CRIME-INDUCING DRUGS TOO?

PERMITTING DRUG USE AND ENCOURAGING EVEN GREATER DRUG USE BY LEGALIZATION WOULD PERPETUATE AND EXPAND THE DEVASTATING EFFECTS OF DRUG ABUSE AND ITS RESULTING CRIME.

ANOTHER ERRONEOUS ARGUMENT FOR LEGALIZATION IS BASED ON THE ECONOMIC RATIONALE THAT IT WOULD BE CHEAPER TO PROVIDE DRUGS TO ADDICTS THAN IT IS TO ENFORCE THE LAWS AND PURSUE ANTI-DRUG STRATEGIES. IT WOULD NOT BE CHEAPER. AS THE DRUG USING POPULATION INCREASES, THE COSTS TO SOCIETY FOR THE CRIME AND OTHER DETRIMENTAL HEALTH EFFECTS OF DRUG ABUSE WOULD BE FAR GREATER THAN THEY ARE NOW. WE WOULD STILL REQUIRE THE POLICE, COURTS, PROSECUTORS AND JAILS TO DEAL WITH DRUG RELATED CRIME. WE WOULD NEED TO DRAMATICALLY INCREASE TREATMENT PROGRAMS FOR THOSE WHO, ONCE ON DRUGS, WANT TO GET OFF. AND WE WOULD STILL HAVE THE ECONOMIC IMPACT ON BUSINESS, NOT ONLY IN TERMS OF LOST PRODUCTIVITY, BUT IN TERMS OF INCREASED HEALTH CARE INSURANCE, WORKER SAFTEY AND UNEMPLOYMENT BENEFITS.

EVEN IF IT IS MORE EXPENSIVE TO DO WHAT WE ARE DOING TO ERADICATE THIS PROBLEM, CAN GOVERNMENT'S OBLIGATION TO PROTECT THE PUBLIC SAFETY BE ABDICATED BECAUSE IT IS EXPENSIVE? CLEARLY NOT.

TWO WEEKS AGO ON A NATIONWIDE TELEVISION BROADCAST ON THIS SAME TOPIC, IT WAS SUGGESTED THAT ANTI-DRUG LAW ENFORCEMENT EFFORTS, NOW ESTIMATED AT $8 BILLION NATIONWIDE, COULD BE CUT TO $2 BILLION IF DRUGS WERE LEGALIZED. HOW CAN WE SAY THAT IT $8 BILLION IS TOO MUCH TO SPEND? HOW MUCH IS TOO MUCH? EARLIER THIS YEAR I READ IN THE WASHINGTON POST THAT LEADERS OF THE INFAMOUS MEDELLIN DRUG CARTEL OFFERRED TO PAY OFF COLUMBIA'S ESTIMATED $15 BILLION NATIONAL DEBT IN RETURN FOR IMMUNITY FROM PROSECTUTION AND THE SCRAPPING OF THE COUNTRY'S EXTRADITION TREATY WITH THE U.S. THIS HANDFUL OF INDIVIDUALS WERE WILLING TO SPEND ALMOST TWICE AS MUCH TO STAY IN THE GAME THAN WE, AT 240 MILLION STRONG, ARE TO KEEP THEM OUT. I THINK THAT IT IS ALL TOO PAINFULLY OBVIOUS THAT $8 BILLION IS NOT NEARLY ENOUGH AND WE NEED TO COMMIT MORE - - IN THE RIGHT PLACES.

PART OF OUR PROBLEM HAS BEEN A LACK OF NATIONAL COMMITMENT, - - NOT ON THE PART OF THE AVERAGE AMERICAN, BUT BY THOSE WHO ARE REPRESENTING THEM. THE TOUGH CHOICES THAT HAVE TO BE MADE ARE NOT BEING MADE. WHILE THE 1986 OMNIBUS DRUG BILL AUTHORIZED $230 MILLION FOR DRUG LAW ENFORCEMENT, ONLY $70 MILLION WAS ACTUALLY APPROPRIATED. WHY? THE MOST COMMON EXCUSE IS THAT THERE'S NO MORE MONEY FOR ANYTHING SINCE GRAMM-RUDMAN. LET'S FACE IT, UNLESS WE FIND A NEW REVENUE STREAM FOR FUNDING ANTI-NARCOTICS EFFORTS, WE MAY NEVER BE ABLE TO ADEQUATELY ADDRESS OUR NEEDS.

ON A NUMBER OF OCCASIONS OVER THE PAST YEAR I HAVE SUGGESTED A THREE YEAR FEDERAL INCOME TAX SURCHARGE DEDICATED SOLELY TO ELIMINATING THE DRUG PROBLEM. I BELIEVE THAT THE AMERICAN PUBLIC WOULD SUPPORT SUCH A TAX IF IT WERE PROPOSED IN THIS CONTEXT. HOWEVER, IN THIS ELECTION YEAR, EVERYONE IN WASHINGTON IS LOATHE TO MENTION THAT "T" WORD FOR ANY PURPOSE. I BELIEVE THAT THAT IS TERRIBLY SHORTSIGHTED.

NOW I'M NOT THROWING THE ENTIRE BURDEN IN THE LAP OF THE FEDERAL GOVERNMENT, BUT I THINK YOU'LL AGREE THAT WHETHER IT'S LOS ANGELES, NEW YORK, UTICA OR TOPEKA, ON ITS OWN, A CITY CAN'T WIN THE WAR ON DRUGS, WASHINGTON MUST DO ITS JOB TOO.

THE CITIES ARE ALREADY DOING THEIR PART. NEW YORK CITY, IN PARTICULAR, IS DEDICATED TO DO WHATEVER IT CAN IN TERMS OF FIGHTING THE DRUG WAR. WITH 1,400 OFFICERS DEDICATED SOLELY TO NARCOTICS INTERDICTION, WE ARE SPENDING NEARLY HALF A BILLION DOLLARS IN CITY MONEY TO ADDRESS ALL ASPECTS OF DRUG CONTROL.

BUT I PLAN TO DO MORE. BUILDING ON THE SUCCESS OF A SPECIAL POLICE UNIT WE ORGANIZED LAST SPRING, THE "TACTICAL NARCOTICS TEAM" (TNT), WHICH WAS USED TO CLEAN UP A PARTICULARLY DRUG INFESTED AREA OF QUEENS, I AM IN THE PROCESS OF EXPANDING ITS EFFORTS CITYWIDE WITH CLOSE TO 650 ADDITIONAL OFFICERS.

THIS HUGE EXPANSION OF OUR DRUG ENFORCEMENT EFFORTS WILL OBVIOUSLY PUT PRESSURE ON OUR CRIMINAL JUSTICE SYSTEM. IT WILL NECESSITATE AN INCREASE IN JAIL BEDS OVER AND ABOVE THE 3,800 IN MY CURRENT CAPITAL PLAN AND THE 4,700 ADDED IN THE LAST TWO YEARS.

IT WILL INCREASE THE CASELOADS OF DISTRICT ATTORNEYS AND THE LEGAL AID SOCIETY WHO WILL RECEIVE $9.5 MILLION MORE THAN PREVIOUSLY PLANNED OVER THE NEXT TWO YEARS.

THE TOTAL PRICE TAG FOR THIS EXPANSION: $110 MILLION. HOW WILL I FUND IT? BY MAKING SOME TOUGH DECISIONS - - RAISE TAXES ON CIGARETTES AND ALCOHOL, TEMPORARILY INCREASE LOCAL PROPERTY TAXES OR, IF NEITHER OF THESE ALTERNATIVES ARE SUCCESSFUL, CUT SOME CITY SERVICES. HOWEVER WE DO IT, IT MUST BE DONE.

THE REACTION OF SOME PEOPLE TO MY PROPOSAL HAS BEEN THAT PERHAPS I SHOULD WAIT AND HOPE THE NEXT PRESIDENT AND THE NEW CONGRESS WILL BE ABLE TO DO MORE TO FIGHT DRUGS. BUT THOSE OF US OUT THERE ON THE FRONT LINES, THOSE WHO DEAL ON A DAILY BASIS WITH THE RAVAGES OF THIS WAR SIMPLY CAN'T AFFORD TO WAIT.

MR. CHAIRMAN, WHAT IT COMES DOWN TO IS THIS. WHEN PEOPLE SAY THAT WE SHOULD LEGALIZE DRUGS BECAUSE LAW ENFORCEMENT EFFORTS HAVE FAILED, THEY IGNORE THE FACT THAT A TRULY EFFECTIVE WAR HAS YET TO BE LAUNCHED AGAINST DRUGS. WHAT WE REALLY NEED TO DO IS MORE, NOT LESS. A REAL WAR ON DRUGS MUST INCLUDE INTERDICTION OF ILLICIT DRUGS BY THE ARMED FORCES AT THE BORDERS, IN THE AIR AND ON THE HIGH SEAS. IT MUST INCLUDE MORE FEDERAL FUNDING FOR EDUCATION AND TREATMENT ON DEMAND. IT MUST INCLUDE "FEDERALIZATION" OF DRUG PROSECUTION AND INCARCERATION. THESE ARE ALL IDEAS I'VE LAID OUT IN DETAIL IN PREVIOUS FORUMS. I WILL CONTINUE TO STRIVE TO SEE THAT THEY BECOME PART OF THE ARSENAL IN THE WAR ON DRUGS.

IT IS TIME TO RAISE THE BATTLE FLAG, NOT WAVE THE WHITE ONE.

THE CITY OF NEW YORK
OFFICE OF THE MAYOR
NEW YORK, N.Y. 10007

December 6, 1988

Mr. Ulrich H. Dembowski
Select Committee on Narcotics
Abuse and Control
H.R. - 234 House Office Building Annex
Washington, D.C. 20515-6425

Dear Mr. Dembowski:

Enclosed you will find the letters of support for the Needle Exchange Program, which were to be included with Mayor Koch's testimony in our letter of November 7, 1988.

I extend my apologies for this oversight and for any inconvenience it may have caused.

If I can be of any further help, please do not hesitate to contact me.

Sincerely,

Mary Kate Adams

Mary Kate Adams
Intergovernmental Relations

SUPPORTERS OF NEEDLE EXCHANGE PROGRAM
(Letters attached)

1) C. Everett Koop, MD, Surgeon General

2) David J. Sencer, MD, MPH, former New York City Commissioner of Health

3) William Wasserman, MPH, New York State Committee of Methadone Program Administrators

4) Leon Eisenberg, MD, Harvard Medical School, Dept. of Social Medicine and Health Policy

5) Robert G. Newman, MD, President, Beth Israel Medical Center

6) Bailus Walker, Jr., President, American Public Health Association

7) June E. Osborn, MD, Dean, University of Michigan School of Public Health

8) Robert S. Bernstein, MD, President, New York County Medical Center

ADDITIONAL SUPPORTERS OF NEEDLE EXCHANGE PROGRAMS
(No letters attached)

9) Donald Des Jarlais, MD, New York State Office of Substance Abuse

10) City of Boston, Department of Health

11) City of San Francisco, Department of Health

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

The Surgeon General of the
Public Health Service
Washington DC 20201

The Honorable Edward I. Koch
Mayor, The City of New York
New York, New York 10007

Dear Ed:

In the matter of providing needles and syringes for IV drug abusers as part of a program to halt the spread of HIV, I have always said the same things publicially and will repeat them here very briefly.

1. If a needle and/or syringe program could contain in any way the spread of HIV who could possibly be against it?

2. The mistake should not be made of trying to transfer the experience of one country and/or culture to another. It might not necessarily work.

3. No program should be undertaken unless there is a pilot program well conceived, well monitored, and well evaluated.

4. The study must be large enough to take into account the natural loss of participants because of the fragmented nature of IV drug abusers and the natural tendency of any participant to drop out of such a study.

5. Participants in a pilot program should not be chosen from lists of individuals who are waiting for admission to a slot in an IV drug abuser treatment program even though the prospect of such an available slot is not immediate. Once the resolve of an IV drug abuser has been made to the point of applying for treatment it is immoral to offer him an alternative that takes him back into his former habit.

I hope this is helpful to you, Ed. Criticism comes very easy to people like me. We just have to get thicker skins.

My best to you.

Sincerely yours,

C. Everett Koop, M.D.
Surgeon General

(Signed original will be sent as soon as possible.)

165 ALLANDALE ROAD
BOSTON, MASSACHUSETTS 02130

7 October 1988

Edward I. Koch
Mayor
City of New York
City Hall
New York, NY 10007

Dear Ed,

In August of 1985 I wrote you:

> "The sharing of needles and syringes among drug abusers is the second most common manner in which the virus associated with AIDS is transmitted. (Now the most common!)...
>
> "An intravenous drug abuser is not addicted to the needle or syringe but to the material injected. Prevention and therapy of drug abuse should be directed to the addicting substance, not the mode of use.
>
> "We are condemning large numbers of addicts to death from AIDS (by not allowing them access to sterile needles and syringes). A live addict may be amenable to treatment of his drug abuse. An addict infected with the virus continues the spread of AIDS not only to other addicts, but to their sex partners, and tragically to children born of such parents."

This is still the situation three years later.

The City is being accused of promoting genocide by offering to save lives by preventing the spread of AIDS to addicted persons, their sexual partners and to unborn children. Is it genocide to provide a clean needle and syringe in a program that puts addicted persons in touch with health personnel? Or is the current Federal approach to drug problems the true culprit?

Treatment of drug addiction historically has been a Federal responsibility, but the Reagan administration has systematically slashed support to treatment. The President's Special Advisor on Drugs - a physician - asserts that addiction is a crime, not an illness. This attitude is criminal.

The New York State Department of Health has approved a project to determine if providing heroin users clean needles and syringes will prevent the transmission of AIDS. At the same time this project will bring addicted persons to the attention of health professionals. I urge you to continue your support of good public health and your fight for additional resources for treatment.

Sincerely,

Dave

David J. Sencer, MD, MPH

2785

COMPA | The New York State Committee of Methadone Program Administrators

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William Wasserman

Vice Chairperson
James R. Quinn

Treasurer
Irv Finkelstein

Secretary
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Paul Samuels
R Wilson Schiller

Executive Director
Martin Livenstein

435 Second Avenue
New York, NY 10010

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HEALTH COMM.
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October 12, 1988

Hon. Edward I. Koch, Mayor
City of New York
City Hall
New York, N.Y. 10007

Your Honor:

As Chairperson of C.O.M.P.A. and the Director of Montefiore Medical Center's substance abuse treatment program I am writing in favor of the needle exchange experiment soon to be started by the NYC Department of Health. I'm grateful to Mr. Mahoney, Mr. McKinley, and Mr. Eaton of NYC Health Department who made a brief presentation at our October 7 general membership meeting.

Intravenous drug users (IVDUs) have contributed 34% of New York City's AIDS cases to date, and this understates the problem by omitting the dramatic increases in non-AIDS morbidity in NYC IVDUs observed by the Health Department since 1981. This excess illness and death is attributable in part to widescale infection of New York's 200,000 IVDUs with Human Immunodeficiency Virus (HIV).

Our ability to effectively control the spread of HIV infection balances on our ability to motivate abandonment of behaviors that carry the risk of infection with HIV such as sharing contaminated injection apparatus. To that end, the needle exchange scheme is a well designed research project designed to improve our understanding of the behaviors of IVDUs and the effectiveness of a program that has shown favorable results in other countries. I am pleased that the City is again accepting a share of the responsibility for the public health consequences of untreated addiction, and impressed that you are willing to incur a political risk to discover information of vital importance to all citizens.

I ask that you be mindful that needle exchange schemes in Amsterdam and London have increased the demand for long term drug abuse treatment. The total C.O.M.P.A. membership (consisting of over 100 programs) treat slightly in excess of 35,000 addicts statewide, and including ALL existing drug abuse treatment 'slots' in the state only one in five addicts can find room in existing programs.

(more)

Hon. E. Koch
Oct. 12, 1988
page 2 of 2

Addressing this gap requires bold and vigorous leadership. The epidemic of AIDS and HIV fostered illnesses mandates a direct response to the appalling lack of sufficient and competent substance abuse treatment for all New Yorkers in need, and the needle exchange experiment is a sound step in that direction. I hope we can count on you to continue your support for expanding the availability of services to treat all drug users.

Sincerely,

W Wasserman

William Wasserman, MPH

cc: C. Eaton
S. Joseph, M.D. ✓

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HARVARD MEDICAL SCHOOL
Department of Social Medicine and Health Policy

LEON EISENBERG, M.D., Chairman
Presley Professor of Social Medicine
and Professor of Psychiatry

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617-732-1710

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COMMISSIONER OF HEALTH
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12 October 1988

Mayor Edward I. Koch
City Hall
New York, NY 10013

Dear Mayor Koch:

I urge you to continue your support for the experimental needle exchange program proposed by the New York City Health Department in order to limit the spread of AIDS.

As a member of the Institute of Medicine National Academy of Sciences Committee on a National Strategy for AIDS, I know how essential it is that we explore every avenue to control the epidemic of this lethal disease. Because IV drug addicts have become the major link in the transmission chain on the East Coast, we cannot afford to overlook any measure with the potential to slow this process.

Of course, every effort should be made to provide drug treatment programs for those addicts prepared to undergo treatment. However, even if treatment slots were available for all potential enrollees, that would not suffice to assure disease control. The fact is that many IV drug users refuse to enter treatment; others defect after entry. Furthermore, treatment is far from uniformly successful and relapse after initial success remains common. Therefore, it is imperative to explore alternate means to reduce disease transmission so long as IV drug use continues.

Needle exchange is no panacea. However, experience in Western Europe and in the United Kingdom indicates that it does reduce the use of contaminated equipment. Enrolled addicts not only lower the risk for themselves and for others but are more likely to enter treatment at a later date because of the relationship established between the user and the public health workers who provide clean "works."

Obviously, it would be far better if it were possible to abolish drug abuse. Unfortunately, despite the rhetoric about interdiction and demand reduction, abolition remains an unattainable goal for the foreseeable future. Given the reality that drug abuse will continue in the near term, it is crucial that we employ every plausible means of containing spread of AIDS, a disease which has had devastating consequences, especially in the minority community.

I congratulate you on your decision to support needle exchange. I trust that your commitment will not to be deterred by the vociferous but uninformed opposition to this program. If the health of the community is to be protected, our elected officials must have the courage to exercise effective leadership.

Yours sincerely,

Leon Eisenberg, M.D.

LE:CF

BETH ISRAEL MEDICAL CENTER FIRST AVENUE AT 16TH STREET, NEW YORK, NY 10003 (212) 420-2873

Robert G. Newman, M.D.
PRESIDENT

October 7, 1988

Mayor Edward I. Koch
The City of New York
Office of the Mayor
New York, NY 10007

Dear Mayor Koch:

Intravenous drug use is the highest risk behavior associated with the spread of AIDS, and drug addicts are the primary route of contagion to the heterosexual population and to neonates. Any effort to lessen this risk must be applauded and encouraged.

The City Health Department, with appropriate caution, has proposed a small pilot study to determine the feasibility and the effectiveness of "needle exchange." Only by such a trial will the impact of this approach be removed from the realm of unfounded speculation, and allow objective and unbiased assessment. The existing peril - to drug users and to the general community - is so enormous that it would be irresponsible not to explore every option that might prove helpful. Accordingly, I urge you to continue to support Commissioner Joseph in his efforts to initiate this investigational program.

Sincerely yours,

Robert G. Newman, M.D.

bcc: Stephen C. Joseph, M.D.

Dr. Joseph

AMERICAN PUBLIC HEALTH ASSOCIATION
1015 Fifteenth Street, N.W., Washington, D.C. 20005 • (202) 789-5600

BAILUS WALKER, Jr., Ph.D., M.P.H., President

School of Public Health
State University of New York
Empire State Plaza
2523 Corning Tower
Albany, New York 12237

October 7, 1988

The Honorable Edward I. Koch
Mayor
City Hall
New York, New York 10007

Dear Mayor Koch:

As President of the American Public Health Association, the world's oldest and largest organization of public health professionals, I endorse your proposal for a pilot needle exchange program to alter the course of the AIDS epidemic.

At the outset, I must tell you that I have in the past opposed such an approach. But after a careful study of the AIDS problem, visits to many "high risk communities" across the country, and consultation with long-time students of the drug abuse problem, I now support pilot projects because I firmly believe that all of us charged with protecting the public health have a clear responsibility to provide leadership -- undefiled by budget, politics or status-seeking motivation -- when the consequences of certain types of behavior have serious health outcomes affecting whole communities.

The AIDS epidemic is a deeply troubling public health issue -- so serious that we must pursue aggressively all reasonable approaches to addressing the biomedical, social and epidemiologic dimensions of this fatal disease. It is not difficult for the interested observer to discern the need for a more sophisticated and objective analysis of the AIDS problem as a social phenomenon to complement the strictly biomedical and epidemiological analysis. All of this we must translate into constructive political and programmatic response.

In my view, New York City's proposed needle exchange program provides an excellent opportunity for engaging patients of addictive diseases in counseling and encouraging more of them to come to treatment to interrupt current exposure to illicit drugs. It also can help us to develop a badly needed data base that would make possible wise choices among policy options.

Thus, I would strongly urge that a carefully designed case-control epidemiologic study be an integral component of the needle exchange program and that the results be shared with the public health community.

As I told the Presidential Commission on the Human Immunodeficiency Virus Epidemic when I testified earlier this year in Washington, the public interest is best served when policies designed to deal with AIDS issues are based on scientific knowledge and not on fear, prejudice, morality or political ideology.

Finally, I would strongly urge you to use your influence to mobilize more of the community in support of expanded drug treatment programs, including a broad range of support services for drug abusers.

Sincerely,

BAILUS WALKER, JR.
PRESIDENT

cc: Stephen C. Joseph, M.D.

The University of Michigan 2703

SCHOOL OF PUBLIC HEALTH

OFFICE OF THE DEAN

109 SOUTH OBSERVATORY STREET
ANN ARBOR, MICHIGAN 48109-2029

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October 10, 1988

Mayor Edward I. Koch
Mayor of New York City
New York City Hall
New York, NY 10013

Dear Mayor Koch:

I am writing to confirm my earlier comments to you concerning the wisdom of your programs exploring the usefulness of needle exchange. As you know, I strongly endorse this aspect of the overall effort to contain the AIDS epidemic which is such a serious and potentially disastrous threat. Clearly needle exchange is not the whole answer, nor should it even be a central issue. However, while we accommodate for more and better treatment opportunities for persons caught up in intravenous drug use, it seems to me absolutely crucial that we facilitate their avoidance of the AIDS virus by making needle exchange opportunities available.

I must commend you for your courage and endurance in taking this stand, which I know to be quite a difficult one politically. If it helps at all, it is my impression that those places which have adopted needle exchange programs have definitely not experienced increase in drug use per se, and there is some evidence that the needle exchange option has indeed facilitated increased access of drug users to health care and to potential rescue from the threat of AIDS.

With best regards,

Sincerely yours,

June E. Osborn M.D.

June E. Osborn, M.D.
Dean

cc: Commissioner Stephen Joseph

NEW YORK COUNTY MEDICAL SOCIETY
40 West 57th Street, New York, NY 10019
Telephone (212) 399-0040

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The Mayor
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October 18, 1988

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Gary A. Gatza

Stephen C. Joseph, MD, MPH
Commissioner
New York City Department of Health
125 Worth Street
New York, NY 10013

Dear Commissioner Joseph:

The Board of Directors of the New York County Medical Society at its October 11, 1988 meeting, reviewed the New York City Department of Health's "Needle Exchange Pilot Program." The Society and its membership are greatly concerned about the transmission of the human immunodeficiency virus (HIV) and the growing number of intravenous drug abusers who are transmitting it. The Society strongly believes that the New York City Department of Health has a very important set of obligations to reach out to this community.

Upon review of the needle exchange program description, the Board raised a number of concerns. First, although it was agreed that a pilot program was the only possible way to move forward with a program such as this, members were concerned about the proposed sample size. Because of the limited number of participants, the Department may not be able to comfortably extrapolate the findings and results of this study to a larger population. On the other hand, there was a general concensus by the Board members that the Department of Health might have difficulty in getting participants in general.

The Board was also concerned about the number of needles that would be exchanged. One for a week is certainly a limited number and for the New York City population that would participate in such a program, it may be unrealistic and may generate more problems than it solves.

Again, despite possible design difficulties, the Board agreed that the pilot program is a good first step. Thank you the opportunity to provide input in the development of this program; we look forward to continuing working together.

Sincerely,

Robert S. Bernstein

ROBERT S. BERNSTEIN, MD
President

City of Annapolis

MUNICIPAL BUILDING
160 DUKE OF GLOUCESTER STREET
ANNAPOLIS, MARYLAND 21401

DENNIS CALLAHAN
Mayor

Annap. 263-790
Balto. 269-013
Wash. 261-112

TESTIMONY SUBMITTED BY:

THE HONORABLE DENNIS CALLAHAN, MAYOR, ANNAPOLIS, MARYLAND,

BEFORE THE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL,

THURSDAY, SEPTEMBER 29, 1988

==

Chairman Rangel, members of the committee, my name is Dennis Callahan and I am the Mayor of Annapolis, Maryland, a city of 40,000 located approximately 45 miles from where we are sitting today. I'm proud to say my city was the subject of a twenty-eight page feature in the August,1988 issue of National Geographic Magazine which was entitled **"ANNAPOLIS - Camelot on the Bay."** But...there is trouble in Camelot!

I am here to tell you that no community is free of the drug menace today...that no community can afford to ignore the problem...and that every community has an opportunity to rid itself of drugs and drug dealers if it is willing to stand together and fight this problem.

The legalization of drugs arguments seem to rest on the assumption that drug laws - not drugs themselves - cause the most damage to our society.

The crime of drugs is not a crime against property...but a crime against our youth, our society, and our future. Drugs represent an attack against our very moral fiber. How can we equate the cost of police overtime or additional law enforcement officers as compared to the life of a child?

I consider the abandonment of drug laws as both dangerous and a forsaking of our basic principles. We would, in effect, be giving up the war before the battles have been fought.

The sudden willingness of some elected officials to contemplate legalization cones not as an endorsement of drugs - they say - but a cry of desperation. We must reject this kind of thinking. Cheaper drugs, with their newfound mantle of legal respectability, would unquestionably result in wider use. The damage - particularly in the case of cocaine - could be extraordinarily high.

Let me pose these questions: How much does society pay because drugs are illegal? And how much does society pay because drugs are harmful? A recent study conducted by the Research Triangle Institute estimated that drug abuse costs this nation $60 billion - $24 billion was from drug related crimes; $33 billion was from loss of productivity, injury and other damage by heavy drug users.

Let's compare these startling figures with alcohol abuse with the understanding that the consumption of alcohol is legal in this country. Alcohol abuse costs our society $117 billion...only $2.6 billion were criminal justice costs. The rest came from impaired productivity, motor vehicle crashes resulting in injury and death, and diseases such as cancer and cirrhosis of the liver.

Society's increasingly bitter experience with alcohol abuse is the strongest argument against the legalization of dangerous drugs.

Further, our experience with alcohol indicates that legalization does NOT prevent children from using drugs, it does NOT eliminate the black market, nor does it stop thousands from killing themselves and others. Perhaps law enforcement expenses would decrease - but health care costs would certainly increase...to say nothing about the costs associated with the regulation of production, establishing subsidies, and so on.

Fortunately, attitudes about drugs are beginning to change, but legalization would stop our positive educational processes because it would be interpreted as a signal from our elected leadership that drugs are somehow "O.K."

With the tide of public opinion turning towards stronger law enforcement and greater public funding of anti-drug programs, now is NOT the time to be giving up. I firmly believe the legalization issue flies in the face of public opinion and the scientific evidence of the physical and psychological damage substance abuse causes.

In my opinion, legalization has NOTHING TO DO with law, finance, or taxes. It is an ETHICAL AND MORAL QUESTION which has EVERYTHING TO DO with what we desire for ourselves and our children. As a society, we have a social obligation to prevent an entire generation from becoming non-productive citizens for the rest of their lives. News headlines tell us everyday of violent crimes being committed by people who have their minds warped on drugs. A recent study at the Maryland Shock Trauma Center based on data collected between July, 1985 and May, 1986 showed that more than one-third of the patients treated there had used marijuana several hours before being seriously injured - a finding that one doctor said challenges the widewpread notion that marijuana is a "safe" drug. And if marijuana was considered to be the "drug of choice" in the 1970's...and cocaine seems to be the "drug of choice" in the 1980's...then what will be the "drug of choice" in the 1990's and beyond? What drugs will you consider "safe" for your children and grandchildren in the future? What drugs would it be OK for your surgeon, airline pilot, police officer, or Conrail locomotive engineer to take moments before going to their jobs?

It is also a question of leadership and courage...leadership by elected officials - and courage of the community. If I might be permitted a somewhat personal reflection, I would like to tell you of a housing project in Annapolis known as Boston Heights. This particular area has the reputation of being one of the worst housing projects in our area. Apartment units were in disrepair, garbage was strewn everywhere, the smell of urine and human feces permeated the stairwells...and drug dealing was open and rampant.

In June of this year, I visited Boston Heights with other public officials and the members of my Mayor's Task Force on Substance Abuse. It was widely reported in the local press that I made that visit attired in a very fashionable bullet-proof vest. That is true, because a few weeks earlier, the Bureau of Alcohol, Tobacco, and Firearms, Department of the Treasury, had received information from a reliable source that a so-called Jamaican posse has put out a contract on me as a result of my strong public stance against drugs and drug dealers. Although I cannot speculate on the accuracy of this report, it is true that about the same time, we had an incident where twenty rounds were fired from a semi-automatic weapon into a residence in a public housing project. Subsequent investigation of that incident resulted in the arrest of a suspect who has been charged with two counts of assault with intent to murder.

During our visit to Boston Heights, we were appalled at what we saw...Beirut seemed more habitable! We met face to face with the residents of Boston Heights. We promised to clean up their project - with their help - and organized a community clean-up day that very weekend. We also distributed a card with a toll-free drug hotline (1-800-752-DRUG) and asked the good people living in bad circumstances to help us clean out the drug dealers, too.

I'm pleased to show you this headline...and this editorial...both of which appeared in our local press. The drug bust, which resulted in the arrest of four drug dealers, the confiscation of $8,000 in cash, $26,000 worth of cocaine, and assorted weapons, was made possible by tips from people who live in the community...people who are fed up with trying to raise their families in a drug-infested environment...and who just needed the assurance that their efforts would be supported by political leadership and law enforcement officials. I believe the residents saw that we had the personal courage to support them... and they knew they could support us in our efforts to get rid of drugs and drug dealers in their neighborhood.

This may not be the kind of story that makes the evening TV news, but it is proof-positive that a pro-active program to rid our City of drugs and drug dealers can and does work!

History proves we cannot win any war by surrendering. If I might quote Sir Winston Churchill's stirring words spoken as his nation was being threatened by what many considered to be an overwhelming enemy..."Victory at all costs, victory in spite of all terror, victory however long and hard the road may be; for without victory there is no survival."

Thank you for the opportunity of addressing you this afternoon...

Statement

of

JOHN C. LAWN
Administrator
Drug Enforcement Administration

before

the

Select Committee on Narcotics Abuse and Control
U.S. House of Representatives

concerning

The Legalization of Illicit Drugs

on

September 29, 1988

Mr. Chairman, Members of the House Select Committee on Narcotics Abuse and Control: I am pleased to appear before you today to discuss the issue of the legalization of illicit drugs.

Let me state from the start that I am unalterably opposed to legalizing any illicit drug for general use. As I have said many times: "Drugs are not bad because they are illegal. They are illegal because they are bad."

I believe it important that we do not confuse the dialogue today with another matter often cast under the rubric of legalization, and that is rescheduling of drugs to permit their use in therapeutic settings. My remarks today will focus on the issue before this committee -- the legalization of illicit drugs as a drug abuse and crime control strategy.

I welcome this discussion on legalization. Armed with facts and historical data developed through forums such as this one, we can put the legalization issue to rest once and for all.

Americans are used to quick fixes for our problems. Those of us who are concerned with both drug supply and demand reduction have long recognized, however, that there are no quick solutions. The drug problem has been a long time developing. And, it will take time to correct. We must allow our relatively recent drug abuse prevention and education programs to take root.

The major flaw in the legalization theory is that it misses the point. Drugs themselves, not drug laws, cause the most damage to society.

We need to profit from the our country's involvement with alcohol. Dr. Mark Kleiman, a criminal justice expert who teaches at Harvard University, said: "I think the experience with alcohol is the strongest argument against legalization of illicit drugs."

In the decade before prohibition went into effect in 1920, alcohol consumption in the United States averaged 2.6 gallons per person per year. Prohibition dramatically changed that picture. Average consumption fell to 0.73 gallons during the prohibition decade. Now, individual consumption is back to 2.6 gallons. This historic perspective clearly illustrates a very important point -- greater availability results in greater use and greater abuse.

Today's alcohol abuse statistics are frightening. The National Council on Alcoholism says that one out of every three American adults claim alcohol abuse has brought trouble to their families. In 1985, nearly 100,000 ten and eleven-year-olds reported getting drunk at least once a week. We can attribute over 100,000 deaths a year in the United States to alcoholism. Over 23,000 are on our highways alone.

These statistics dramatically illustrate our current experience with alcohol. But, we can also learn from this country's earlier experiences with cocaine and heroin. At the turn of the century, these drugs were legal in the United States. The number of addicts was at its peak during that period -- higher than any other time in our history. As a result, the Harrison Narcotics Act was passed in 1914 to restrict the public's access to these drugs. In the years that followed, reports of cocaine and heroin addiction fell significantly.

What would happen if cocaine were once again to be made legal? A former director of the National Institute on Drug Abuse made a shocking prediction based on what we know about alcohol addiction given its unrestricted access. He estimated that if there were no drug enforcement in the United States to limit access to cocaine, there would be about 80 million regular users of this reinforcing drug in our country, instead of the roughly 6 million now regularly using cocaine.

We must learn from our earlier experiences involving the legal availability of cocaine and heroin. We must also learn from our experiences with legal systems of drug distribution. We currently have a system in this country to distribute methadone, an analgesic used in heroin detoxification and treatment. Since the 1970's, we have provided free methadone through treatment clinics. Although in many situations there is no problem, the system is by no means perfect. A black market in methadone has evolved because while methadone addresses the maintenance dose, it does not satisfy the abuser's need to get high. As a result, many methadone users continue to abuse this and other drugs, including heroin.

Methadone is not our only experience with legal drug distribution systems. Today in this country we have a government-regulated and controlled system of dispensing drugs. As part of the "closed" distribution chain created when Congress passed the Controlled Substances Act of 1970, all legitimate handlers of substances controlled under Schedules I through V of the Act are required to obtain an annual registration from DEA. These handlers include pharmacies, practitioners, hospitals, clinics, and teaching institutes.

But, even with this government-regulated and very controlled system, we still have a major licit drug problem in the United States. Just under one-half of all drug-related emergency room episodes are attributed to legal drugs. Over 20 million of our citizens use prescription drugs for nonmedical reasons. The problem stems from the misuse and the diversion of controlled substances.

We can indeed profit from our nation's experiences with prescription drugs, as well as with illicit substances. We can also profit from the experiences of other nations. Many proponents of drug legalization point to the British system.

Since 1968, specially licensed physicians have been permitted to prescribe heroin to addicts. But, in reality, it is a myth that this system is a success.

Drug addiction levels in Britain have increased rather than decreased since the system was put in place. Since 1979, addiction to opiates, primarily heroin, has more than tripled in Britain, and cheap black market heroin has flooded England.

We must learn from the British experience. The past is a great teacher. To paraphrase an old maxim: "We must learn from history or we are doomed to repeat it." History has shown us time and again that when addictive drugs are socially accepted and easily available, their use is associated with a high incidence of individual and social damage.

History is an important teacher. With those perspectives in mind, we must now also consider what the legalization of drugs would do to our future.

I believe that legalization would send the wrong message to the rest of the world. The United States would violate international treaties we are signatories to if we were to create a legal market in cocaine, heroin, marijuana, or other dangerous drugs. The United States is a signatory to the Single Convention on Narcotics Drugs of 1961 and the Convention on Psychotropic Substances of 1971. These treaties obligate us to establish and maintain effective controls on substances covered by the treaties. United States violation of these treaties would destroy our credibility with drug source and drug transit countries that are now working with us in the global war on drugs.

It is also my opinion that legalization would send the wrong message to our nation's youth. At a time when we have urged our young people to "just say no" to drugs, legalization would suggest that they only say no until they are older. It stands to reason that children would be confused about the real consequences of drug abuse when drugs are forbidden to them, but are readily available to others only slightly older. If drugs were socially acceptable, it is likely that more children, anxious to act "grown up," would yield to peer pressure to use drugs.

As I said a moment ago, I also believe that legalization would expand the drug problem. Medical research with rats, for example, demonstrates that given unlimited access, rats will continue using cocaine to the exclusion of food and water until they die. But, in more human terms, we can look at the countless stories of lives destroyed by the cocaine and crack epidemic in our midst. If these reinforcing drugs were freely available, we could reasonably expect that the current crisis we now face -- particularly in our large cities -- would increase substantially.

We know that drug law enforcement deters drug use. In fact, I recently saw a survey where over 70 percent of the high school students in New Jersey and about 60 percent of the students in California said that the fear of getting in trouble with the law constituted a major reason not to use drugs.

As a father of four children, I am deeply concerned about what effect legalization would have on our youth. As the nation's chief drug law enforcement officer, I am deeply concerned about the effect legalization would have on crime in this country. It is my strong belief that legalization would not eliminate or decrease drug-related crime. A popular misconception is that drug users commit crimes solely to support expensive drug habits. This misconception leads to the false conclusion that lowering the cost of drugs would reduce the level of crime. In reality, cheaper, legal drugs would probably increase the level of violent and property crime.

Never before has cocaine been available in this country at such low costs and such high potency levels as we are seeing today. Cocaine and its derivative, crack, have contributed significantly to the recent increases in violent crime in our major metropolitan areas. Recent Drug Use Forecasting statistics indicate that cocaine use by those arrested for non-drug felonies has almost doubled during the last three years in New York City. And, here in our nation's capital, that number has more than tripled.

Even legalization proponents concede that other crimes, such as child abuse and assaults, that are committed because people are under the influence of drugs would not decrease. Dr. Robert Gilkeson, Director of the Center for Drug Education and Brain Research, said that "drug use is actually the cause of sociopathic and 'criminal' behavior." Drug users commit crimes that are totally unrelated to the cost of drugs. For example, last year in Philadelphia, one-half of child abuse fatalities involved a parent who was a heavy user of cocaine. It stands to reason that the increased drug use caused by legalization would result in a surge in incidences of random violence and higher crime rates.

Those advocating legalization profess that such an action would eliminate a black market and organized crime's involvement in selling drugs. However, to see their argument to its logical conclusion, they must be advocating universal availability. That means that they would legalize and allow anyone to have any drug of any potency -- without any restriction whatsoever. Our reality is, however, that no one is advocating that children have ready access, or that hallucinogens such as PCP be freely available.

It is important to recognize that the instant any one control, such as age or drug type or potency, is imposed, you must establish a regulatory system. Once that is done, you create a void that would undoubtedly be filled by a black market.

If our nation were to opt for universal availability, the black market in drugs would disappear, but a black plague of drug addiction, overdose deaths, and crime would take its place.

Some proponents talk about how legalization would save the government money. In the first place, as I noted earlier, regulatory and enforcement costs would increase substantially. Second, if other crime, especially violent crime, were to escalate as I predict it would with freer drug availability, law enforcement and criminal justice system costs would increase. Furthermore, I do not believe that there is a city in America that would welcome, much less accept, a reduction in their police force. In short, the projected billions saved on law enforcement costs is a specious, hypothetical argument.

But, more importantly, my question is how can you place a dollar value on the wasted lives, shattered careers, and broken homes that I believe that the legalization of illicit drugs would bring. But, if we must look at costs, it would be instructive to look at certain figures. Based on Employee Assistance Program referrals, it is estimated that each year drug abuse costs business $7,000 per drug-abusing employee, which is about 10 percent of our workforce. Drug abuse will probably cost the United States upwards of $100 billion this year in lost productivity, absenteeism, and related health expenses. Legalization would undoubtedly increase those costs.

And finally, it is important to recognize that legalization would jeopardize the safety of our society. Drugs dull the ability to think and react quickly. Studies have shown that drug users are 3 to 4 times more likely to be involved in on-the-job accidents than non-users. What work environment could sustain a high level of workplace accidents? The increasing numbers of companies using drug testing is a testament to business and industry's concern about keeping drugs out of the workplace. It is absolutely inappropriate or considered backpedalling on the advances we have begun to make on drug abuse in the workplace.

Drugs and any form of transportation do not mix. The result has too often been deadly. How many more have to die as a result of a train engineer who smoked marijuana? How many more have to be in jeopardy or die as a result of a pilot high on drugs? Do you want the mechanic fixing the brakes on your car to have ready access to drugs that will remain in his system long afterwards?

There is no real hue and cry from the American people for the legalization or decriminalization of illicit substances. Recent Gallop and ABC News polls showed widespread opposition to legalization proposals. In the ABC News poll, for example, 9 out of 10 Americans reject the decriminalization of all illicit drugs, with a majority saying that legalization would lead to increased drug use.

Legalization is offered as a simplistic answer to an extremely complex issue. The real answer to the drug problem in America today is not legalization. Character reconstruction, not the dismantling of drug laws, is the answer. Our focus must be to reduce the demand, as well as the supply of drugs. Instead of giving in by way of faulty approaches like legalization, we need to work together to do everything possible to win our nation's war on drugs.

Mr. Chairman, this concludes my remarks. I will be pleased to answer any questions you may have.

NATIONAL DISTRICT ATTORNEYS ASSOCIATION
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TESTIMONY

OF

ARTHUR C. EADS

CHAIRMAN OF THE BOARD
NATIONAL DISTRICT ATTORNEYS ASSOCIATION

DISTRICT ATTORNEY
27th JUDICIAL DISTRICT
BELTON, TEXAS

BEFORE

SELECT COMMITTEE ON NARCOTICS

HEARINGS
ON

THE SUBJECT OF LEGALIZATION

SEPTEMBER 29, 1988

WASHINGTON, D.C.

Good morning Mr. Chairman and members of the Committee. I appreciate the opportunity to appear before the Committee and share the perspective of prosecutors across the country on this important issue. I am Arthur C. "Cappy" Eads, District Attorney of Bell County, Texas, and Chairman of the Board of Directors of the National District Attorneys Association. NDAA has a membership of some 7,000 prosecutors, the overwhelming majority of whom have direct experience with litigating drug-related crimes.

The National District Attorneys Association opposes legalization of drugs. We further believe the debate over legalization deflects and delays our efforts to combat the crisis in drug use effectively. It is our hope that the whole question of legalization can soon be put to rest and we can move on to the more difficult challenge of developing appropriate responses to this national tragedy. As prosecutors with on-line experience with the effects of drugs--on both the user and those around him or her--we are in no mood to give up and embrace the panacea of legalization simply because the problem is so massive. We fully acknowledge the scope of the problem and are prepared to work hard toward its resolution.

You have been a strong voice, Mr. Chairman, for addressing the problem of drugs aggressively. NDAA commends your leadership on this issue of national importance and looks forward to continued support of this Committee's war on drugs. Prosecutors have put a number of programs to fight drugs in place already. We would be happy to discuss these with you at a later date.

The National District Attorneys Association opposes the legalization of currently illicit drugs for the following reasons:

1. **Legalization ignores the fundamental reason why drugs were made illegal in the first place.** Put most simply, drugs are illegal because they are bad for society. Why? They harm the person who uses them and those around him or her.

Recognition of the physical and emotional damage drugs have on their users was a primary motivation in establishing law enforcement barriers between drug suppliers and drug users. Addiction, pain, loss of judgment, injury, loss of earning power, failure to thrive, inability to learn and grow to potential, and--to an increasing extent--early death from overdoses or the dangerous environment many drug users frequent, are all reflective of the toll drugs take on their users. As social service agencies, hospital emergency rooms and morgue workers can attest, the harmful effect of drugs on users is not a matter of academic discussion but a fact.

The impact of drug use on others is equally devastating and equally incontestable. Family breakdowns, community decay, economic ruin, and the entire range of criminal behavior have been directly attributable to the purchase, sale and use of drugs. Antisocial behavior resulting from drugs is played out publicly through wars in the streets over drug markets and privately in the suffering of children whose parents neglect, abuse and even murder them under the influence of drugs. More and more newborns come into life already addicted and in desperate pain because of the drug habits of their mothers. More and more neighborhoods have good cause to fear the violence and irrational brutality of their drug-using members. This is not a matter of conjecture. It is also not a situation that would disappear were drugs legally available.

In New York City, child abuse and neglect cases related to the crack cocaine epidemic have increased 225%. In Washington State, 70% of child abuse and neglect cases are related to drug abuse. Throughout the country, child abuse reports and foster care placements are rising because of the plague of drug use and its frequent byproduct, domestic violence and misery.

How can we experiment with legalizing drugs when the evidence of their destructiveness surrounds us? Given our knowledge of the consequences of drug use, this alone should be sufficient grounds for opposing legalization.

2. **The benefits claimed for legalization or decriminalization are overstated and in large measure unachievable.** Legalization proponents claim that if illicit drugs were legalized and controlled administratively through regulation, that illegal drug trafficking would cease and crimes committed by drug users would dramatically decline. Furthermore, they claim the money currently spent on drug law enforcement could be transferred to prevention and treatment programs.

Let's look at the real world. A strong black market in drugs will persist unless all drugs of all potencies are competitively manufactured and marketed. To eliminate the illicit drug market, pure cocaine, crack, PCP, heroin, and marijuana would have to be available on demand to those who wished to use it, including first time users. It is irresponsible to assume that increased availability and removal of criminal sanctions would not result in an increase in the number of users.

The crime reduction claims made by proponents of legalization and decriminalization are grossly overstated. Claims that drug users commit crimes solely to support expensive drug habits are false. An increase in drug consumption would lead to an increase in the level of violent and property crime since all drugs impair judgment and some release or create violent propensities in the user. We have seen a decline in the price of some drugs. But we have also seen an increase in use as well as an increase in crime related to that use--property crimes and crimes of violence. Crimes such as domestic violence, child abuse and neglect could also be expected to continue apace. The many households in this country that are dysfunctional because of drug use (including alcohol) would not become less so with decriminalization or legalization.

The need for control over access to drugs will continue to exist, with or without legalization. The need, therefore, for law enforcement's involvement with drug trafficking surveillance and apprehension of manufacturers and dealers will remain.

The claim that funding for drug-related law enforcement could be transferred to drug-related education and treatment efforts wrongly assumes these two areas are distinct and in competition. In fact, prosecutors strongly support treatment programs. They are an essential ingredient in drug offender sentencing. The funding currently available to prosecutors' offices for fighting drug crimes is used for a wide variety of efforts that take account of community needs. A neat transfer of funds, as popularly envisioned by legalization proponents, is therefore unlikely.

3. **Legal sanctions against drug use are a critical component of effective prevention and treatment programs.** There is overwhelming agreement among drug offender treatment specialists that criminal sanctions, when used effectively, can assist in keeping the offender drug-free and in treatment. It also provides for the offender a bright line regarding what is and is not acceptable behavior. Law enforcement is a means of holding the offender accountable and compelling treatment while insuring the offender remains drug-free when under the control of the justice system.

To legalize drugs and simultaneously preach against their use sends a contradictory message to offenders and potential users, especially young people. The same may be said for giving needles to I.V. drug users. If we believe drug use is wrong and dangerous, why would we remove barriers to their use? We have an ethical obligation to protect children, to send clear messages about what is tolerable and intolerable. Legalization would have a negative impact on that objective. The law's equivalent of prevention is called general deterrence which simply means that persons are deterred from committing crimes because of the fear of punishment as set by the example of those who commit crimes that are caught and punished. Legalization removes any current benefit we now enjoy as a result of general deterrence.

Some legalization advocates suggest that by giving away drugs through clinics, users will be enticed into treatment. This may be so for those users who would seek treatment anyway and who are not already caught up in the criminal justice system. Treatment should be available on demand for those individuals. It is not true of the many offenders who would avoid treatment if not legally coerced. The DUI (driving under the influence) alcohol laws exemplify the value of legally required treatment. Thousands of alcohol abusers arrested on DUI charges have received treatment they needed but never would have undertaken without the coercive force of the law.

4. **Legalization of drugs would have a disproportionately negative impact on poor communities.** Although substance abuse affects all economic groups, its impact on communities that already suffer poorer schools, fewer services, greater unemployment, and far fewer opportunities to succeed is unquestionably far greater than in affluent communities where drug use may also thrive. Many young people and adults in inner cities have turned to drugs to escape the misery of their surroundings. Some have become wealthy as drug dealers. While legalization would perhaps reduce the number of drug marketeers, it would simply reinforce for users the legitimacy of this avenue of escape.

Interestingly, many of the those most opposed to legalization are minority leaders who are deeply concerned about the effects of drug use on their communities. We should heed their words.

5. **A full-scale war on drugs combining law enforcement, prevention and treatment efforts has yet to be tested.** We should not have to choose between law enforcement and prevention and treatment programs. We need to support each with our will and our resources. Why should we accept drugs as a necessary evil before making a broad-based concentrated effort to eliminate their use? The battle has so far been fought in skirmishes--an interdiction program here, a school campaign there, tougher sentences here, mandated treatment there. In very few communities is there sustained interdisciplinary effort bringing the best of criminal justice, medical, and educational forces to bear on the problem. Either funding, turf, politics or simply other pressures get in the way--sorry excuses in the long run if the battle against drugs is lost.

The American people have lost confidence in their government's ability to deal with the drug crisis. Local prosecutors have a critical role to play in rebuilding public confidence in the rule of law. No drug dealer should escape punishment because law enforcement lacks training, resources or expertise. No user should escape accountability for behavior that endangers himself and others. No offender should be free in the community if he continues to use drugs whether convicted of a drug offense or any other offense.

We have to find a way to assure the public that the more than one million convicted criminals who are on probation or parole in our communities on any given day are drug-free. They must be compelled to remain drug free through regular testing for drugs and in treatment while under the control of the criminal justice system. If they fail to meet these standards they must be incarcerated. Today, many communities do not have the resources to enforce this basic rule.

Mr. Chairman, we have no illusions about total victory. Let's get serious about fighting drugs. To prosecutors and 90% of the American public, according to an ABC news poll, legalization is not an option. Let's not waste any more time talking about giving up when lives are literally being lost in the streets every day. Let's take on this battle and win it.

TESTIMONY BY

THE INTERNATIONAL ASSOCIATION OF CHIEFS OF POLICE

JERALD R. VAUGHN, EXECUTIVE DIRECTOR

CONCERNING

LEGALIZATION OF DRUGS

BEFORE THE HOUSE SELECT COMMITTEE
ON NARCOTICS ABUSE AND CONTROL

SEPTEMBER 29, 1988

TESTIMONY OF JERALD R. VAUGHN, EXECUTIVE DIRECTOR OF THE INTERNATIONAL ASSOCIATION OF CHIEFS OF POLICE BEFORE THE HOUSE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL. CHAIRMAN: CONGRESSMAN CHARLES B. RANGEL

Honorable Congressman Charles B. Rangel, Chairman, and members of the House Select Committee on Narcotics Abuse and Control. Good Morning. My name is Jerald R. Vaughn and I am the Executive Director of the International Association of Chiefs of Police. This organization, the IACP, is a professional membership organization and I represent approximately 15,000 chiefs of police, sheriffs, and other law enforcement executives from the United States and sixty eight other nations. I firmly believe that my remarks here today are not only representative of the members of my Association, but reflective of the entire law enforcement community.

I first want to thank Congressman Charles B. Rangel for inviting me to present to you on this critical and urgent subject. We are shocked and appalled at the mere suggestion that the legalization of illicit drugs is an option or solution to the drug problem we face in the United States. We refuse to discuss or debate this spurious "option." As far as the law enforcement community is concerned, there is no debate. Drugs are diabolical and destructive not only to the human system, but to the democratic way of life and a responsible citizenry. Therefore, I am not here today to "debate."

Let me say at the outset that I believe that those who advocate legalization have conveniently forgotten that controlled dangerous substances are first and foremost detrimental to the physical health of people. Drugs, whether marijuana, crack/cocaine, LSD, heroin, paint thinners or amphetamines are unsafe, a serious health risk, and in many cases a life and death issue. Addiction and dependence are the most heinous outcomes of the ingestion of illicit drugs, but let me remind you of other effects that the casual and unsuspecting user can expect:

- Constricted blood vessels, high blood pressure, angina, irregular heart beats, brain hemorrhages, seizures, damage to the vocal chords, erosion to the cartilage in the nose, muscle deterioration, kidney failure, paranoia and schizophrenia.

- Intravenous drug users face hepatitis, AIDS, skin infections, tetanus, inflammation and breakdown of medium and small arteries in the kidneys, muscles, gastrointestinal tract and heart.

- And what of unborn and newborn infants? What of those who arrive in the greatest nation on earth already addicted to one of the most destructive forces created by mankind. Recent statistics out of Broward County, Florida cited that one of every eight babies born is subject to withdrawal symptoms as a result of a mother who is a regular cocaine user. The impact of marijuana on fetal development includes low infant birth weight, premature births, birth defects such as clubfoot, congenital heart disease, spina bifida, and hydrocephalus as well as difficulties for the mother throughout pregnancy. And a related curse of contemporary society? A short life expectancy for the infant born with AIDS. Think about that for a moment.

Therefore, I believe that in your deliberations you must first consider the welfare of the general population of the United States and accept the fact that legalization and illicit drugs are first and foremost a health issue; your overriding concern must be to protect people; adults, youth and infants alike, from unsafe substances.

My second concern, and I would underline this, we cannot predict the impact of legalization on the general population. Pro legalizers blithely and cavalierly ignore discussions as to the numbers of individuals currently using drugs and of those additional individuals who will become recreational users and ultimately addicts with the advent of legalization. Generally, the pro legalizer adheres to the self control theory of drug usage and avers that in a free environment people will simply control the amount of usage to ensure a safe, casual and pleasurable intake of the drug. Let me suggest to this committee that we have no sound and solid statistics upon which to base predictions of the impact of legally and easily accessible drugs. In fact we are only now, in 1988, beginning to locate the iceberg, let alone probe its depths. Most of our estimates as to the actual numbers using drugs are extrapolated from interviews with individuals who we expect will honestly report to us on their illicit activity. How many users become addicted? We simply do not know ... some say 75% as compared to 10% of those who use alcohol and eventually become alcoholics. We don't know how many middle class professionals use drugs and turn their productive lives into lives of chaos and secrecy. We don't know how many judges, attorneys, government administrators, doctors, nurses or airline pilots use illegal substances. Members of these groups can seek treatment and rehabilitation "quietly."

New statistics from the National Institute of Justice show that 70% of arrestees test positive for drugs, and 90% of individuals committing acts of violence are either under the influence of alcohol, drugs or both. We now know that Mothers Against Drunk Drivers need to become Mothers Against Drunk and Drugged Drivers. Statistics are beginning to be generated by hospitals and clinics who treat the disastrous accident results. We can now tell you how many serious accidents are the result of an operator who tests positive for drugs but we cannot tell you how many minor accidents are caused by a driver who is under the influence of drugs. We know how many deaths due to overdose occur annually, but we do not know how many minor illnesses, related medical costs, absence from work, poor productivity, dropouts from school or society, and other irresponsible behavior occurs due to illicit drugs. Police records can tell us how many "reported" domestic violence and child abuse incidents occur in the United States annually, but we have no way of knowing how many physical beatings, cases of psychological abuse or neglect, divorce, malnutrition and other victim consequences occur as a result of a wage earner enjoying a regular drug ritual. If we legalize drugs, we will certainly discover the truth about this hidden menace quickly - but at a point in our history when it may be too late. The costs of rehabilitation, treatment, protection and the repair of broken lives may be beyond our ability to pay. We are already facing an unknown health bill due to the AIDS epidemic; one would think that we would not need to generate a second major health crisis in this century.

Allow me a moment to speak to the absurdities of the primary arguments proffered by the pro legalizers. They charge law enforcement with being ineffective in the war on drugs. The truth is, comparatively speaking, that we have just arrived at the edge of the battle field. We have just begun to test the effectiveness of methods to develop new and powerful strategies and work with a committed and concerned community as well as develop new partnerships among federal, state and local law enforcement agencies. Is this the time to yield and walk away whimpering?

Pro legalizers fantasize that legalization will reduce crime and violence. Are they predicting that addicted users will remain employed? Ludicrous! These poor souls will still have to generate an illegal source of ready cash. Black markets and robberies of government dispensaries will support those who either have habits or for whom drug dealing is their everyday job. Do you honestly believe that those who now accrue large sums of money through drug dealing will suddenly acquire legitimate job skills and become law abiding, family oriented citizens? And what of the inner city youths, cut off from middle class employment and a quality of life portrayed on television by a "Chemical Apartheid." Will these young citizens voluntarily take their hand out of the cookie jar of plenty and return to either unemployment or the all too minimum wage scale? Are you convinced that legalization will miraculously change all of this?

Pro legalizers promote the idea that law enforcement is using too many scarce public resources in the war on drugs and that legalization will dramatically make those sums available for other needed services. Has anyone computed the costs of rehabilitation, treatment, unemployment and welfare payments? Has anyone conjectured the costs to this nation of broken families, and youth who will never come close to realizing their potential because they were sidetracked through a field of corruption and villainous forces provided by their very own government? Should we exchange a battle against a known enemy for one against a multi headed hydra?

And finally, I would address that argument which contains the power to undermine this republic. That could pose a threat to this constitutionally established democratic government that so highly values individual and civil rights. The pro legalizers moan that legal restrictions on drug use and availability is an infringement on civil and individual rights. Let me assure this committee that we as a nation have seen fit to regulate the sale and distribution of harmful substances since the 1700's and no one has yet decried rights infringement. We protect our citizens from diseased meats, poultry and seafood, false branding and marking of food substances, poorly prepared serums and vaccines, food additives, food coloring, milk, alcoholic beverages and dangerous nonprescription drugs. We regulate these consumer products because we cannot depend upon producers and manufacturers to place the consumer before profit. The consumer has no way of judging, without personal experience, the ill effects of food products. Our citizens depend upon the United States government to provide them protection from unsafe and potentially dangerous substances. Are we going to fail them now? Are we going to turn our backs on the unborn, the new born? Are we going to abandon our international neighbors who are struggling on their own soil? Prime Minister Margaret Thatcher was quoted recently in a warning to drug pushers in Great Britain as saying: "We are after you! The pursuit will be relentless! We shall make (your) life not worth living!" Isn't this the side we are on?

Now let me paint another picture for you. The quality of a democracy depends upon the levels of responsibility exercised by its citizens. Can you envision a democratic government choosing to administer debilitating drugs at low costs to its young adults and citizens? Substances that will ultimately reduce the strength and best resource of our nation to the responsibility level of a somnambulant drone?

I believe that legalization is antithetical to our democratic way of life and that we should dismiss these hallucinations of a "quick fix." Is there a moral issue here? Yes, one would have to question the morality of a group of legislators in a democracy willing to reverse its stance and confuse our youth; one would have to question the morality of a government willing to open the floodgates of danger, death and irresponsibility to its own citizens.

Is there any question in your minds as to my position on the legalization "debate?" Legalization is an absurd proposition bordering on lunacy. We in law enforcement, have accepted the challenge. We are convinced that we will defeat this modern Goliath through strength, determination, discipline and a commitment to democratic values - we will not win by surrendering. I strongly urge you to conclude these hearings; do not waste any more valuable time; do not risk neutralizing our efforts by broadcasting an inconsistent or confusing message. Reject this seductive siren called legalization and return your solid support to the drug enforcement efforts. Let me remind you that when a professional mountain climber encounters a sheer rock face he does not pale and seek an easier route; he draws upon his best and strongest skills. I suggest we do the same.

I have attached to my testimony a comprehensive drug enforcement strategy prepared by the IACP. Thank you.

The International Association of Chiefs of Police is a professional organization comprised of over 14,500 top law enforcement executives from the United States and 68 nations. IACP members lead and manage several hundred thousand law enforcement officers and civilian employees in international, federal, state and local governments. Members in the United States direct the nation's largest city police departments including New York City, Los Angeles, Chicago, Detroit, Houston and others, as well as suburban and rural departments throughout the country.

Since 1893, the IACP has facilitated the exchange of important information among police administrators and promoted the highest possible standards of performance and conduct within the police profession. This work is carried out by functionally oriented committees consisting of police practitioners with a high degree of expertise that provide contemporary information on trends, issues and experiences in policing for development of cooperative strategies, new and innovative programs and positions for adoption through resolution by the association.

Throughout its existence, the IACP has been devoted to the cause of crime prevention and the fair and impartial enforcement of laws with respect for constitutional and fundamental human rights.

Jerald R. Vaughn was appointed executive director of the 14,500-member International Association of Chiefs of Police on September 10, 1985. Established in 1893, the IACP currently has members in 68 nations.

As the executive director, Vaughn oversees all organizational activities at IACP's World Headquarters near Washington, D.C. and each of its international regional division offices. He has over 20 years of progressively responsible police experience, including having served as the chief of police in two cities. He was decorated for service above and beyond the call of duty by the governor of the state of Colorado while serving as an undercover agent in a federally funded drug task force. He holds a master's degree in public administration and a bachelor's degree in the administration of justice.

Director Vaughn serves on the United Nations Commission on Narcotics and Dangerous Drugs in Vienna, Austria and is the IACP representative to Interpol in St. Cloud, France. He is on the advisory boards of the FBI/DEA Sports Drug Awareness Council, the National Institute Against Prejudice and Violence, the Federal Law Enforcement Training Center and the Law Enforcement Memorial Trust. He is on the 13-member National Law Enforcement Council and has served as the chairman of the Law Enforcement Steering Committee, which is comprised of the major police representative organizations in the United States. He served as the cofacilitator of the National Cooperative Drug Strategy and Demand Reduction Project, which was a joint endeavor by the IACP, the Drug Enforcement Administration and the Justice Department's Bureau of Justice Assistance. He oversees the Police Policy Resource Center and the Deadly Force Reduction Program of IACP. He is editor-in-chief of *Police Chief* magazine, *IACP News,* and the *Journal of Police Science and Administration.*

COMBATTING THE DRUG PROBLEM IN THE UNITED STATES

"We can no longer afford the disease—
and seem unwilling to pay for the cure."

INTERNATIONAL ASSOCIATION OF CHIEFS OF POLICE
Jerald R. Vaughn
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SINCE 1893

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MAR 4 1989

COMBATTING THE DRUG PROBLEM IN THE UNITED STATES

Preface

Over 60 percent of the illegal drugs in the world are consumed in the United States. Drug abuse and its corresponding impact on crime, particularly violent crime, our economy, the future of our young people and indeed our basic value system, rips at the very fabric of our society. Drugs have become the most serious threat to the domestic security of our nation and consequently, our national interests, are jeopardized.

Every President since Lyndon Johnson has declared war on drugs, yet the problem not only persists, it has grown steadily worse. Public awareness of the problem is greater now than ever before, but we still continue to lose this war.

The police are in the trenches and on the front lines in the war on drugs. Many give their lives or suffer permanently disabling injuries in the battle. Many become cynical and question whether there is a drug war at all or just superficial tough talk that lacks real substance and determination by our elected officials and the public at large. A few police officers succumb to the temptation of big and easy money and engage in corrupt activities. Many others out of frustration become complacent and direct their efforts toward activities that have more tangible results. The police, probably more so than others, see firsthand the tragic consequences of drug abuse and the toll it takes on human life, individual dignity and in pain and suffering that cannot be measured. They see the absurdity of the claim that drug abuse is a victimless crime. The victims are very real and exist in substantial numbers. The police themselves become victims through senseless acts of violence and other side effects of drugs in our society.

The police, those in our society closest to the problem, have often been left out, ignored or dismissed in the debate about how to deal with our national drug problem. The police recognize the complexity of the problem and know that there is no simple or easy solution. There is no quick fix. They are increasingly more frustrated and perplexed that common sense measures are often overlooked; that positive action is displaced by inaction resulting from endless debate and what might be appropriately described as "analysis paralysis." Clearly, if America is to halt the devastating impact of the drug abuse epidemic we are currently experiencing, then the time for action is now. We simply cannot afford the cost of inaction. We must move forward in a deliberate, decisive, rational and reasoned manner that has positive results as its objective. To that end, the International Association of Chiefs of Police has developed a position that is articulated in this document, on those measures we believe are necessary to achieve that objective. We have purposely directed our comments primarily to those areas wherein we have the greatest expertise--law enforcement and criminal justice. We recognize the critical role of education, prevention, treatment, and parental responsibility in the solution to the drug problem and encourage those with expertise in those areas to immediately identify measures that must be taken to deal with this major health threat facing us. We invite them to work with us developing a comprehensive, broad-based approach that includes all elements of the community because drug abuse is not a police problem, but rather a social and community problem that will ultimately be solved at that level.

Criminals must know that our society has meaningful and significant sanctions it is willing to impose in a swift, certain, fair manner that will serve as an example to others for those who import, distribute or consume drugs. Those basic requisites of punishment have broken down and must be restored in order to fight the enemy in this drug war. For those reasons, many of the measures will require extraordinary political courage, perseverance and commitment of financial resources. One thing is abundantly clear, we are on a collision course that undermines an orderly, democratic society if we do not come to grips with our drug problem. We must act and act now. The measures identified herein represent the consensus views of America's police leaders in addressing what has become a blight on our society--drug abuse.

Necessary Actions

1. Emphatically oppose the legalization or decriminalization of drugs.

Drugs are not bad because they are illegal--they are illegal because they are bad. The misery, death, and destruction on society resulting from the use of drugs is well documented. To engage in any debate about legalization is to give legitimacy to a movement that ultimately is detrimental to the health, welfare and safety of all American citizens. Society should not compromise reasonable values held by decent people in pursuit of simplistic solutions to our complex drug problem. To suggest that legalizing drugs will cure our crime problem is naive and unrealistic. Similarly, efforts to decriminalize marijuana, a proven gateway drug, when THC content has increased from five to eight percent through the use of hydroponics (in some cases the content is found to be 13 to 14 percent in varieties of sinsemilla) are dangerous and misdirected.

While much is being said about the failure of the law enforcement approach to solving the drug problem, the fact is law enforcement has done its job well as evidenced by jammed court dockets and overcrowded jails and prisons. It is the other parts of the criminal justice system which are underfunded and undersupported that have been unable to handle what law enforcement has generated, thus undermining the basic requisites for punishment of criminal behavior. Instead of dealing with the inadequacies of the criminal justice system, some are attempting to move us toward legalization which at best is a superficial solution that has a price attached much higher than this nation may be willing or able to pay.

2. Oppose measures and programs that facilitate drug abuse and concomitant criminal behavior.

The exchange of needles for intravenous drug users or the distribution of other paraphernalia that facilitates the illegal use of drugs is nothing less than aiding and abetting criminal acts. To sustain drug abuse through such shallow and contradictory programs is an abrogation of civic and social responsibility and should be totally unacceptable in a society plagued with a drug problem the magnitude of ours.

Where a legitimate health risk is at issue, treatment, not continued drug abuse, is the only sensible alternative. The federal government should terminate all forms of federal assistance to jurisdictions that allow programs that facilitate illegal drug abuse to operate.

3. Ensure that users of illicit drugs are held accountable for their criminal conduct.

Despite law enforcement successes in apprehending unprecedented numbers of drug related offenders and record breaking seizures of illicit drugs and drug-related assets, drug abuse continues to threaten the welfare of our society. The police community recognizes that as long as a significant portion of American citizens continue to demand the use of illicit drugs, there will always be drug traffickers willing to take the risk of incarceration. While demand reduction strategies primarily focus on prevention and education, it would prove to be more effective if used in conjunction with a carefully designed and prudent deterrence oriented strategy that reinforces each citizen's right and responsibility to live, work and be educated in a drug free environment by holding those accountable that choose to consume illicit drugs. User accountability programs focus on a punitive approach which seeks to deter drug abuse through criminal and/or societal sanctions that send a powerful message that drug use will not be tolerated. Drug users are co-conspirators in criminal cartels that deal in death, corruption, and extreme violence. It is the user that supplies the reason for the trafficker and producer to exist. Users cannot escape responsibility for their actions which are wreaking havoc on our society. In pursuit of user accountability, the programs must be constitutionally sound, flexible, tempered with fairness and have popular and institutional support. They can include such measures as incarceration, fines, revocation of driving privileges, seizure of property such as vehicles, mandated community service, drug testing and mandatory drug education programs. We must recognize that adding new sanctions without the necessary resource support is meaningless and only serves as further inducement to violate the law.

4. Correct the funding problem in our entire criminal justice system.

Resources allocated to the law enforcement end of the federal and many state and local governments have been bolstered in response to the growing drug problem. All of the arrests and seizures resulting from that effort, however, are having little impact because the rest of the system is clogged to the point of dysfunction. While we only spend .06% of the federal budget for law enforcement and 1.4% of total government spending at the federal, state and local level for the provision of police services, and only 3% of total government spending for our entire civil and criminal justice system, which includes police, prosecutors, courts and prisons. The United States devotes the lowest level of resources to the public safety function of any democratic nation in the free world on a per capita basis. The amount spent is simply inadequate to deal with the serious crime and drug problems we are experiencing. We must correct the problems of overcrowded courts, overworked and inadequate numbers of prosecutors and seriously overcrowded jails and prisons. We must address this problem as a "system" problem. There must be corresponding and proportionate increases at each step of the process to ensure that the system works efficiently and meets the intended objective of dealing with criminal offenders. We must be careful not to throw money wildly at the drug problem and expect that to be the solution. We have learned a lot in the past two decades.

Funds should be allocated into results oriented, community based strategies where the bulk of the funds are allocated to operational rather than administrative or bureaucratic activities. Every effort should be made to utilize practitioners rather than career bureaucrats in the decision process about funding and program design.

Where will the money come from? First, it is time to recognize that government can't be all things to all people. Instead of trying to fund everything, programs of lesser priority should be abolished and domestic security, i.e., the public safety function should be beefed up with existing resources. Second, if the drug problem is of the level of concern to citizens that public opinion polls suggest, then let citizens have the opportunity to direct more new resources into the battle by a voluntary check-off on their income tax forms for an earmarked drug or public safety fund. Third, it is time to shift the burden of prison funding from the taxpayer back to the criminal where it belongs. We should expand prison industries programs through repeal or substantial modification of the Hawes/Cooper and Ashurst/Sumners Acts which prohibit the intra and interstate sale of prison-made goods on the open market. Prisons can and should become more self-supporting. Nonproductive prisoners are unacceptable given the enormous financial burden they represent. The Department of Defense is currently attempting to close down over 20 military bases in the United States *but can't* because of Congressional pressure to keep them open due to the economic impact on the community. These facilities should be converted to minimum and medium security prison facilities for nonviolent offenders, thus freeing up traditional, more secure prisons for drug dealers, violent criminals and repeat offenders.

5. Increase federal assistance to state and local law enforcement and increase the number of joint task forces with federal, state and local agencies participating.

The drug problem is simply beyond the ability of most local governments to fund. If ongoing, meaningful investigations and anti-drug activities are to occur, then the federal government must increase the level of assistance. The dynamics of drug trafficking are such that there is no respect for city limits, county lines or state boundaries. The drug problem is truly a national and international issue that will require a tremendous shared commitment at all levels. The greatest amount of success has been experienced when there has been cooperation among federal, state and local agencies. We should capitalize on this success by placing more of our resources in this area.

6. Correct the deficiency in the national drug policy board.

The current National Drug Policy Board has one fatal flaw--it precludes the active participation and input of state and local law enforcement. The composition of the board as it currently exists should more appropriately be named the "Federal" Drug Policy Board. Without the input of state and locals, the work of the board will always focus on only part of the total drug problem. It is at the state and local level that the impact of the drug problem is being felt. To ignore the views of local law enforcement in the regular proceedings of the board is ludicrous. The federal government must quit *planning for* and begin *planning with* state and local law enforcement and governmental entities if we are to successfully win this battle. The National Drug Policy Board could and should be restructured to ensure that we truly develop a policy that is national in scope by having representative seats on the board from local government.

7. The public safety function should be elevated in stature and importance to a cabinet level position.

If in fact a national policy on crime and drugs were to be developed, it is unlikely that it would actually be carried out in an efficient or effective manner due to the lack of coordination and in some cases, cooperation, between the myriad of agencies involved. There is considerable research dealing with crime, treatment and rehabilitation and other related subjects, but there is no central authority or responsibility within government to translate this information into action through a comprehensive national program or strategy to effectively deal with the crime and drug problem.

The debate concerning whether or not a drug czar position should be created has been ongoing. IACP has not supported the current legislative proposals on this subject because they do not sufficiently empower any cabinet official to direct other agencies. If we have a drug czar who can only "suggest" a set of priorities, we will be no further along in the war on drugs than we are now. We do not need another powerless layer of bureaucracy.

A drug czar, in our opinion, does not go far enough. We believe the time has come for a cabinet level **"Secretary of Law Enforcement"** to enhance the stature and importance of the public safety function and to be the central focal point in government to improve the level of coordination, cooperation and communication between the various federal, state and local law enforcement agencies. The federal law enforcement agencies, especially those within the Departments of the Treasury and Justice, would be transferred to be under the authority of the Secretary of Law Enforcement, but would retain their separate identities. By ending many of the turf battles, duplicative efforts and competitiveness that often exists to the detriment of the law enforcement function, we should be able to achieve more with resources that already exist. We also believe it is imperative to have a position of "Undersecretary for State and Local Law Enforcement" whose responsibility it would be to aggressively ensure the highest level of cooperation between federal, state and local law enforcement by identifying problem areas and immediately beginning to resolve them. The undersecretary would ensure that state and local interests are represented and met in order to facilitate a national crime strategy that really works.

The mechanism for the realignment as recommended above exists under Title 5, Section 901A, of the U.S. Code (Government Organization and Employees).

8. Better utilize the military for logistical and technical support, especially to protect our borders.

We would strongly oppose the use of the military to carry out the civilian law enforcement function within the borders of the United States. However, use of the tremendous technical capabilities, equipment and logistical support of the military is easily justifiable; the more skilled our military becomes in protecting our borders from drug traffickers, the more skilled they will become in protecting our borders from any threat. The training value alone in getting military personnel combat ready through utilization in closely supervised and carefully defined drug missions outside and along our borders cannot be underestimated. While the military is already providing assistance in the drug war, there is a much larger support role that it could play to its benefit. The military is too large and valuable a resource to ignore in dealing with the biggest threat to our domestic security posed by drug abuse.

9. Create a National Narcotics Violator Tracking System.

There is presently no system to provide a comprehensive tracking method of narcotics violators as they do business in multiple jurisdictions. Many violators, both adult and juvenile, have extensive criminal records, yet there is no assurance that a jurisdiction investigating such individuals will have this information in a timely fashion. The increased activity of youth gangs in franchising their operations, such as the Bloods and Crips and Jamaican Posse members, utilizing crack cocaine, represents a growing threat with which we are currently ill-equipped to deal. Such a tracking system is needed to maximize our efforts in dealing with career drug traffickers.

10. Congress and the states should establish a death penalty for narcotics-related homicides.

It is clear that the problem of narcotics-related homicides is totally out of control. The price of a life is viewed as nearly worthless by those engaging in the drug trade. The growing number of innocent citizens killed in the crossfire of drug dealers is an outrage to a civilized society. Let those who choose to engage in such senseless acts of violence know that they will pay the ultimate price. We strongly believe in the deterrent effect of capital punishment for these types of crimes.

11. Recognize the connection between the drug industry and firearms.

It is irrefutable that those who traffic in drugs also traffic in violence, murder and wholesale firearms acquisition. Firearms are a staple of the trade in that they offer protection of the large sums of cash generated in drug deals and the huge caches of drugs awaiting sale. **It is not possible to deal with the drug problem and ignore the firearms problem.** They are inseparable. The lack of any measure of reasonable firearms management in the United States is only fueling the drug fire. The hodge podge of state and local gun laws have created a "stop and shop" situation where drug traffickers go to states that make it ridiculously easy to purchase firearms such as Texas and Virginia, buy them and transport them to states with strict gun laws to protect drug operations. The United States not only wreaks havoc on itself because of its steadfast refusal to deal with the firearms problem, but now we export the problem to other countries in South and Central America. For us, it is drugs in--guns and money out. Efforts of police officials in other countries to deal with drug producers are thwarted because their officers are slaughtered with high powered weapons, many of which are exported illegally from the United States.

Federal firearms offenses should be added to the list of predicate offenses for RICO prosecutions and a strong, national handgun purchaser screening program should be enacted that provides for a waiting period, thorough background investigation of the purchaser, mandatory training and demonstration of proficiency in the lawful use and security of firearms, and the issuance of a permit to the purchaser. This system should be supported by fees charged to the purchaser. We have to stop the guns on demand system that currently exists in over 32 of our states if we are to deal with drug-related violence. Penalties for drug-related crimes involving the use of firearms should be strengthened and include mandatory sentencing provisions.

12. Reduce the amount of plea bargained justice.

The process of plea bargaining has undermined the integrity of our criminal justice system. While many of the funding issues discussed earlier have created the conditions by which the level of plea bargaining occurs, we simply have created a monster that turns drug traffickers right back out onto the street and has eroded the confidence of law abiding citizens in our criminal justice system. Criminals know how plea bargaining work, and use it to their full advantage which is most often to the disadvantage of the community.

There may be an appropriate role for plea bargaining to further the cause of justice on a rare occasion but for the most part, it serves to artificially expedite court proceedings, reduce case loads by subverting justice, provides quick and easy money for defense attorneys and ultimately lets the guilty, most often hardened repeat criminals, off without just punishment for the true criminal act committed.

Strict guidelines need to be developed and implemented regarding the conditions and circumstances under which plea bargaining can occur.

13. Enact strong penalties that are aggressively pursued involving drug related corruption of public officials.

The integrity of government cannot be undermined by drug traffickers who attempt to bribe public officials to engage in any unlawful act, no matter how minor, that would allow drug trafficking to occur or a drug violator to go unpunished. The law abiding public is totally dependent upon their public officials to protect them from the drug menace. Any violation of that trust must be dealt with very strongly and in a way that sets an example to others who may be tempted or foolish enough to engage in corrupt activities. Governments at the federal, state and local level should adopt a "zero tolerance" policy to drug-related corruption and ensure that mechanisms are in place to identify and weed out corruption.

14. Increased economic sanctions should be applied to countries that do not cooperate with drug control efforts.

While foreign aid is a complex issue normally outside the purview of law enforcement, better efforts have to be made to deal with countries which by the very nature of their activities play a role in the threat to our domestic security. The welfare of the United States and its citizens must be put ahead of other countries, particularly those which engage in the production or distribution of drugs. The Secretary of State should take counsel from top law enforcement officials on this matter and work with them to better protect our national interest from drug traffickers.

15. Every effort should be made to take any profit out of drugs.

The full resources of the Internal Revenue Service and state tax agencies should be brought to bear on drug traffickers. Anywhere that laundering of money derived from drugs can be identified, full seizure should be made. The states should enact uniform asset forfeiture laws that provide for an expeditious process to relieve drug traffickers of any benefit of their illegal activities. Public officials should constantly seek new and innovative methods to take the profit out of drugs.

16. Every community should adopt a Drug Free Bill of Rights.

While largely symbolic, it is important that every community make a strong statement about its right to be drug free. A Drug Free Bill of Rights can be adopted through resolution of the governing body and should include the following elements:

- The right of each citizen to live, work, be educated and recreate in a drug free environment.
- The right of every citizen to use public streets and highways free of drivers who are under the influence of or impaired by drugs, including alcohol.
- The right of each citizen to expect its government to aggressively protect a drug free environment by adequately funding drug education and prevention programs, law enforcement services, prosecutorial, judicial and penal functions, treatment facilities and a wholesome social environment.
- The right of the community to impose tough, reasonable sanctions that hold those who engage in drug activity strictly accountable for their actions.

Dealing Drugs in America

WIlliam J. Chambliss

Teammates on the Atlanta Falcons were shocked this week when Joe Croudit died from an overdose of cocaine. Members of the banking community probably were not surprised but nonetheless uneasy when the Bank of Credit and Commerce International, one of the largest banks in the world, was indicted for laundering money from drug trafficking. Joe Croudit was known as a health nut by his teammates. The bank had a reputation for financial solvency, a rare event in today's banking world. The emotional response to the athlete's death and the indictment of the bank officers will doubtless lead to increased enrollment in Nancy Reagan's army of moral entrepreneurs hysterically demanding that people "just say no" while legislators increase the number of police officers and the severity of punishment for drug traffickers.

The result of these efforts will be to increase, not decrease, the number of deaths from drug consumption and the cooperation of other banks in laundering drug profits. As long as the possession and consumption of cocaine, marihuana and heroin are a criminal act we will all bear witness to the carnage caused by impure drugs of varying but undetermined strength and the corruption of bank officials, police officers, government agencies and politicians. Expanded law enforcement effort will only heighten the tragedies that are the inexorable result of criminalizing the sale and use of substances that are much in demand.

The cost of making these drugs illegal is not only the tragedy of disease and death of individuals and the corruption of banks, the costs include the destruction of whole communities, the decimation of entire nations states and the creation of an environment in which criminal organizations flourish on the immense profits generated by illegal drug trafficking.

The gross volume of business in just three drugs, marihuana, cocaine and heroin, has gone from one to one hundred thirty billion dollars a year in the United States in less than fifty years making the business in drugs larger than the gross national product of all but eight nations in the world. Columbia, Panama, Turkey, Pakistan, Afghanistan, Laos, Thailand, Bolivia and, most importantly, the United States are so strongly influenced by drug smugglers and profiteers that ostensibly democratic institutions have become the handmaiden of international narcotics traffickers.

In the United States and elsewhere the military and the CIA have been cooperating with drug smugglers. In Central America The CIA was complicitous in the shipment of cocaine into the United States to finance the illegal shipment of arms to the Contras. During the Vietnam War the military and the CIA aided the shipment of heroin out of the Golden Triangle in order to finance clandestine operations throughout the world and to ensure the support of the hill tribes in the Golden Triangle.

The criminality of the CIA in complicity with drug smugglers fits hand in glove with the wholesale corruption of the political and law enforcement system in America and throughout the world. There is not a single major metropolitan police force in the United States today that is not corrupted by drug dealers. The reasons for this are quite clear: police departments are impotent to control drug trafficking. What they can control is the number of dealers and where they sell. They do this by creating a tolerance policy for selected drug dealers who sell in specified areas (read lower class) of the city thereby making drug dealing invisible to the middle classes while assuring that those who want drugs (whatever their class) will have them readily available. By selectively licensing drug dealers the police reduce the violence associated with drug dealing for they can arrest those who compete with the "licensed" dealers. Indeed, the level of violence associated with drug dealing in America is inversely related to the level of corruption in the police department: the lower the violence in a city the greater the corruption in the police department.

The so-called "war on drugs" goes on apace and the price of illegal drugs declines as suppliers succeed in getting more and more drugs onto the streets thus driving down the price.

Joe Croudit and thousands of other deaths are the inevitable result of trying to control the use of drugs through criminal sanctions. Not only is this impossible but the policy inevitably produces consequences far worse than the drugs themselves. In the eleven states that have de-criminalized the possession and personal use of Marihuana the consumption rate has declined. In countries that make heroin available to addicts through medical doctors the extensive and powerful criminal syndicates thriving on drug profits and permeating Americas political and economic life are non-existent. Were marihuana,cocaine and heroin available through state controlled outlets the horrendous price now being paid in death and the corruption of our democratic institutions would be significantly reduced.

Drugs are already available everywhere and this will not and cannot change. Legalizing the possession and use of these drugs will therefore not significantly increase usage. Indeed, the present policy is designed to increase usage as criminal syndicates and individual entrepreneurs work day and night to increase the size of their market. But even if there were an increase in usage and the attendant personal problems associated with addiction and the waste of personal resources, we could deal with these problems more humanely and more rationally through education and community based services financed by taxes on the drugs.

For seventy five years we have pursued a drug policy that can only be described as utter insanity. This policy is an absolute failure. It is time we dropped our hypocritical stance and ceased the incessant moralizing about drugs. It is time to de-criminalize and rationally control marihuana, cocaine and heroin.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Alcohol, Drug Abuse, and
Mental Health Administration
Rockville MD 20857

For Release Only Upon Delivery

STATEMENT

BY

CHARLES R. SCHUSTER, Ph.D.

DIRECTOR

NATIONAL INSTITUTE ON DRUG ABUSE

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

BEFORE THE

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

OF THE

UNITED STATES HOUSE OF REPRESENTATIVES

ON

THE LEGALIZATION OF ILLICIT DRUGS

WASHINGTON, D. C.

10:00 A.M.

SEPTEMBER 29, 1988

ROOM 210, CANNON HOUSE OFFICE BUILDING

Mr. Chairman and Members of the Committee, I am Dr. Charles R. Schuster, Director of the National Institute on Drug Abuse (NIDA), I am grateful for the opportunity to participate in this hearing on the legalization of illicit drugs.

As you know, the issue of legalization has surfaced before. Drug abuse has been a chronic and frustrating problem. All of us, as citizens, parents, employers—in all our roles—wish that it would go away. The frustration extends to police and prosecutors, who must confront drug-related crime and violence on a daily basis with little hint of success. When legalization is proposed, it is generally proposed because of frustration with drug-related crime. The direct cost of this crime is enormous and the cost of fighting it high. Also, the talk of sealing our borders, military intervention on the territory of foreign countries, and stepping up efforts to incarcerate drug abusers raises concern about the erosion of our civil liberties and distortion of our foreign policy as we try to control or detect the use of illicit substances.

While legalization seems to offer a simple solution to the economic problems associated with drug use, there is very little doubt that it will simultaneously exacerbate the health, productivity, and other social problems. A more promising approach is to increase our national demand reduction efforts. We must not forget that drug abuse is not just a law enforcement problem. It is a health problem. Any lessening of restrictions on drug use will inevitably lead to increased use, and more people will develop significant health problems. Can we afford a 20 percent increase in cocaine-related deaths? Can we risk an upsurge in brain damaged people by permitting free access to PCP? Any decrease in violence related to legalization might be balanced by violent acts committed by people whose brain chemistry was altered by drugs. Legalization could create its own set of social problems, and should not be expected to cure the existing ones.

The Department continues to hold a firm position against legalization. It is clear to us that legalization would cost society more than it can afford to pay. In particular, we often think of addiction in terms of its consequences, such as drug-related crime and drug-related health problems. However, it is vital to acknowledge that addiction per se is costly. It represents a loss of freedom, in that addicts have no energy to spare for productive activities and, therefore, no resources with which to change their lives for the better. All their psychological and physical energy must concentrate on the quest for drugs. Addiction is a form of slavery.

However, the price of legalization would be far greater than the loss from "giving up" on current users. We would risk the drug use and its consequences of many, many people—especially youngsters—who are now deterred from experimentation by the legal and moral barriers to such use. Our experience with cigarettes, for example, shows that more than 50 million Americans are willing to risk illness and death for doses of nicotine, which is an addictive drug. We have enormous health and social costs associated with tobacco and alcohol use. Liquor and cigarettes are easy to get; they are legal for adults to purchase. Why should we think that legalized marijuana, or heroin, or cocaine, or PCP, or LSD, would be less aggressively marketed or less appealing to the public?

Those who advocate legalization rarely propose a situation in which dangerous substances are treated in the same way as most other market commodities (i.e., with no controls at all). Generally, the proposals are for decriminalization (under which a substance is controlled but the user suffers no criminal sanctions) or for regulation (under which a substance is available only for specific purposes, usually medical in nature). Proponents of any of these, however, have not presented an operational plan as to how drugs could be made more readily available without harming individuals and incurring excessive social cost.

It has been suggested, for example, that drugs could be dispensed by physicians to people who are certified as already addicted. However, even if such "certified" addicts could be identified, it is doubtful that any physician could be induced to prescribe a dangerous substance for other than therapeutic purposes. The addict/patient would surely not benefit from a continued prescription for cocaine. Cocaine may cause death, whether it is purchased on the street or from a pharmacy. Let me review some of the health consequences of the abuse of various drugs in order to emphasize this point.

Cocaine's best-known danger is to the cardiovascular system. I say it is a well known danger because we have all read of the sudden, unexpected deaths of young athletes who died of myocardial infarctions (heart attacks) following the use of cocaine. Cocaine is among the drugs that accelerate pulse rate and result in hypertension. In some cases, the increased blood pressure in a pregnant woman leads to contractions of the uterus, resulting in miscarriage. Maternal use of cocaine constricts the arteries that lead to the womb, diminishing the oxygen that reaches the fetus. There is some indication that cocaine can cause a fetal stroke.

Heroin, too, can kill. Its use has direct adverse effects on the human body. Since opiates are depressants, overdose can lead to respiratory depression and death. Heroin depresses lung functioning, increasing susceptibility to pulmonary diseases such as pneumonia and tuberculosis. When heroin is adulterated with quinine, it can cause blindness. Because it is often injected by addicts who share needles, it is an important vector in the transmission of HIV. AIDS is spreading rapidly among intravenous drug abusers and, through them, to their sexual partners and their children.

Marijuana is another dangerous substance. Its use may lead to impairment of the immune system. It affects perception, impairing the ability to drive and perform other complex tasks. It can decrease motivation while increasing anxiety and exacerbating preexisting psychiatric illnesses. Recent findings indicate that the drug is capable of damaging areas of the brain involved in learning, memory, and emotions.

Other drugs can have devastating effects on the body, too. Solvent abuse (as in "glue sniffing") has been associated with depression of bone marrow. Withdrawal from amphetamines may yield severe depression. The list goes on an on. In fact, there is no part of the body that can be considered immune to the deleterious effects of drugs.

Getting back specifically to cocaine, during the past few years we have seen a sharp increase of adverse medical consequences resulting from its use. In 1987, a sampling of hospital emergency rooms reported that, compared with 1983, there had been close to a 500 percent increase in the number of times cocaine was involved in a medical crisis (5,200 emergency episodes in 1983 and almost 30,000 in 1987). A sampling of medical examiners reported that cocaine deaths increased from 323 to 1,207 over the same period of time. This increase was foreseen as far back as 1977, when Federal researchers, familiar with the dynamics of the drug distribution system, predicted that a significant drop in cocaine cost would result in an increase in use and serious problems. Cocaine supply grew, costs dropped, and the increased reports of medical emergencies and deaths are the painful results. With decreased costs anticipated as a result of legalization, we would be sanctioning tremendous increases in morbidity and mortality.

I want to turn now to some hopeful signs that indicate a downward trend in the use of drugs and an increase in negative attitudes toward drugs. The NIDA-supported annual survey of high school seniors (Monitoring the Future) showed that cocaine use decreased in 1987, reflecting the first substantial decline among American high school seniors. The use of other illicit drugs also declined, with daily marijuana use falling to 3.3% in 1987 from its peak of 10.7% in 1978. Eighty-seven percent of high school seniors disapproved of even trying cocaine, and 97% disapproved of regular cocaine use.

This is not meant to say that the drug problem is over. Well over half of young people (57%) have tried an illicit drug other than alcohol (which is illegal for this age group) at least once before graduation from high school. Sixty-six percent have used alcohol in the past month, and nearly one-fifth (18.7%) are daily cigarette smokers by the time they leave high school. Obviously, we need to continue our demand reduction efforts.

One promising program is the highly successful effort of the Media-Advertising Partnership for a Drug-Free America, assisted by NIDA, in its drive to "unsell" drug use. Since April, 1987, advertising that discourages the purchase and consumption of illegal drugs and encourages the formation and growth of attitudes and behavior antagonistic toward consumption has been appearing in media all over the country. As a result, all groups (children, teenagers, college students, and adults) have shown attitudes and orientations that became distinctly more antagonistic toward drug use over the past year. The changes were most pronounced in areas of the country with high media exposure. Among college students, where there were marked attitudinal changes, statistically significant declines in cocaine consumption were found, particularly among persons identified as "occasional users."

To sum up, I believe that we need a strong focus on prevention and treatment of drug abuse, but we should not abandon our efforts to control the supply of drugs. Legalization is not the answer. I agree with the Surgeon General, who has said that we must continue to strengthen our efforts to build a national consensus against illegal drugs and to provide treatment to those who have already become casualties. It is a long and difficult road, but we must not make it longer and harder by adding the potholes and pitfalls of legalization.

I will be happy to answer any questions you may have.

DRUG POLICIES FOR A DEMOCRATIC NATION

Testimony of Arnold S. Trebach

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HEARING ON PROPOSALS TO LEGALIZE DRUGS
Select Committee on Narcotics Abuse and Control
U. S. House of Representatives
Washington, D.C.

September 29, 1988

DRUG POLICIES FOR A DEMOCRATIC NATION

Testimony of Arnold S. Trebach

Congressman Rangel, distinguished members of the Committee, honored guests:

We are witnessing a national tragedy. For seven decades, this country has pursued a harmful drug policy. During the Reagan Era, that policy was pushed to what seemed to be its most destructive extremes. After seven years of a multi-billion dollar drug war, our prisons are filled to record levels, violent drug traffickers pollute our cities, and drug abuse is rampant. Despite the most aggressive drug war campaign in history, so much cocaine has been imported since 1981 that the price has dropped to one-third its former level. While some of our children now find it more difficult to buy marijuana, many find it much easier to buy crack and cocaine.

Yet, both major presidential candidates feel constrained to promise only to continue and expand this disaster. The United States Congress is passing laws that will encourage the most extreme actions by the next chief executive. Four more years of the current drug war promise more illegal drugs on our streets, more crime, more Americans in prison, and more youth enticed into drug dealing and drug abuse.

There will soon come a time when we all will look back on the excesses of the current anti-drug campaigns with shame. They will join the roster of national embarrassments that include alcohol Prohibition in the Thirties, internment of Japanese-Americans in the

Forties, McCarthyism in the Fifties, and the Viet Nam War in the Sixties and Seventies. In each case, we eventually sobered up and admitted that we were wrong, that while there was some basis for our actions, we had overreacted in a hysterical fashion.

Now is the time, before any more damage is done, before our leaders further embarrass the American people in the eyes of the world and history, for the healing process to begin in the harsh anti-drug war. In summary form, my proposals for reform are, first, that this nation recognize the futility of the very concept of a war on drugs. Instead we should be fashioning peaceful methods -- those not involving the criminal law or the military -- for curbing drug abuse while preserving constitutional freedoms. Second, we should medicalize the use of marijuana and heroin to ease the suffering of those millions of our citizens afflicted with such diseases as cancer, glaucoma, and multiple sclerosis. Third, we should experiment with various forms of decriminalization or limited legalization of currently outlawed recreational drugs during the remainder of this century. If the experiments work well, we can move on to fuller legalization; if not, we should again invoke the full weight of the criminal law. Fourth, we should invest billions now in new treatment methods and invite the best brains in the nation to participate in attempts to help rather than harm our neighbors who are addicts and abusers.

The leaders of American government and society have played a major role in creating the underlying conditions for the illegal drug markets, for the crime and violence, and for the drug abuse that harm our citizens. They act as if they had no responsibility for these horrors, always preferring to place the blame elsewhere -- on the sixties generation, on foreign dictators, or even on terrorists. Yet, a significant share of the blame for these conditions lies at the feet of draconian drug laws and enforcement policies.

It saddens me to say that part of the blame also is attributable to emotional, misleading statements, such as as you made, Mr. Chairman, in last Sunday's Parade Magazine. The article made it appear that you have made your mind up about this issue, that you may well not listen to any of the evidence, and that this hearing may well be a costly charade. I hope I am wrong but the article made me feel more like an invited object of scorn rather than a witness before a fact-finding body of the legislature of a great democracy. The article was titled, "Give People Hope, Not Drugs." Of course! But all during the time you have been in office, your war policies have ruled and the result has been not hope but hate and drugs. Those policies do not work. Neither does hate. The American people deserve better.

Many of those tough drug laws were passed by the United States Congress and signed by the president on the assurance to the American people that such measures were the only honorable and effective means to deal with the drug menace. These hearings offer us the opportunity to consider more effective and more humane drug policies. I urge the committee to take advantage of that opportunity.

DRUG REFORMERS WANT THE SAME OBJECTIVES AS DRUG WAR SUPPORTERS

Most drug policy reformers and most drug war supporters want similar goals. Certainly, we law reformers want to see our children grow up drug free in a healthy, democratic, and safe society. We want all Americans to be able to walk the streets without worrying about harm from violent criminals. We want the freedom and privacy of all Americans to be preserved and protected by the government. We want the twin scourges of AIDS and drug abuse to be controlled and its victims treated effectively and compassionately by medical authorities and society. We want uncorrupted police institutions capable of providing the intelligent assistance that a democratic people expect of their law enforcement agencies.

We oppose the drug war because it does not bring us these important goals which are vital to a free society with an expanding economy. Indeed, the drug war creates conditions that prevent proper controls on drug abuse, on crime, on corruption, and on invasions of privacy.

Drug war hysteria creates an Orwellian mind-set in which perverse Big Brother tactics are painted red, white, and blue -- and made to appear as patriotic measures to save the soul of America. My upbringing and my old-fashioned New England schooling would lead me to believe it is undignified, unAmerican, and downright perverse for government officials to order female Navy personnel to disrobe and then to observe them eye-to-eye sitting on toilets urinating. Yet, the country is told by its leaders that such perversions -- and a thousand permutations -- are not perversions or in violation of American traditions at all.

Many of us old-fashioned Americans no longer believe our leaders in the White House or here on Capitol Hill when they tell us that they see light at the end of the drug-war tunnel -- and that if only we stay the course in the war, if we have courage to gut it out and commit more troops and treasure, violate just a few more insignificant rights, we can achieve victory. We have heard that line not too long ago in regard to another emotional conflict. And as in Viet Nam, the cause was noble and shared by most decent citizens. Then we fought communism, now drug abuse.

By 1968, however, massive numbers of Americans who opposed communism became opponents of the Viet Nam war as well because they came to believe that it was an ineffective way to save our people from communists. Now, twenty years later, a similar popular revulsion is developing. It is smaller than that against the Asian war but it is large enough and powerful enough to be heard throughout the land, in all major newspapers and on all national media networks, and now, finally at long last, in the halls of Congress through this hearing.

As was the case during Viet Nam, proponents of continuing the war paint the peace movement as being in league with the enemy or even sponsored by them. However, the Viet Nam peace movement came to span such a wide spectrum of respectable political opinion that this gambit was eventually dismissed as a desperate joke. Today, however, fear of being seen as soft on drugs continues to be a vibrant political reality. The staid New York Times was moved to headline a major story on September 11, "Tougher Than Thou." Commenting on a series of harsh drug-war measures passed by overwhelming majorities that week, the Times observed that when it comes to illegal drugs, most members of the House of Representatives "want no enemies to the right of them." The same might have been said of the two major presidential candidates, Messrs. Bush and Dukakis.

Yet, the movement for drug reform continues in the face of this new form of McCarthyism. We reformers oppose drug abuse. Therefore, we oppose the drug war. We propose fundamental changes in American drug policy.

My proposals do not call for full legalization now or in the near future. Accordingly, I have not dealt with many of the detailed questions that were asked of me and other reform witness by the Chairman. I recommend that for the rest of this century we concentrate on policies that operate in the middle ground between full legalization and full prohibition.

8

A BUNDLE OF COMPROMISES

Often, I have been accused of wanting to surrender to drug pushers when I suggested that we should be shopping for points of compromise in the drug conflict. Yet, history shows us Americans at our worst when we refuse to negotiate and at our best when we seek the middle ground in controversies. Indeed, the genius of the American Constitution of 1787 was that it was a bundle of peaceful compromises.

During the past fifteen years, I have written numerous articles, two books, congressional testimony, and other statements that proposed comprehensive reforms in our drug laws and policies. However, I have never called for full legalization nor have any of the organizations with which I have been affiliated. Rather, I have sought to set out a series of compromise proposals over those years. Copies of three sets of those proposals are attached. Discussion of each of them follows.

The Heroin Solution

The first are the major findings and recommendations of my book, The Heroin Solution, 1982. That book was based upon eight years of study of the history of heroin and of the intertwined stories of the development of British and American narcotic laws and policies. The study also included many months of field work in English drug clinics and on the streets of British and American cities, talking to addicts and police. I concluded that the British approach, while full of problems and much maligned by American politicians, worked better than the American because health considerations tended to dominate the national approach to the drug problem. The police and the criminal justice system had a role because crime was involved in the addiction problem there as here, but at a much lower level. Many addicts, I personally saw, were maintained on narcotics and managed to live decent lives. I also applauded the English use of heroin in the treatment of people in pain, especially terminal cancer sufferers.

The Canadian government utilized that book and its findings as part of the scientific support for its historic action in 1986 that brought heroin back into medicine for pain treatment -- as did the Australian Human Rights Commission in recommending similar reforms. The American government continues to ignore the findings.

Several trips to England since the book was completed supported my basic findings. The British system has not failed even though their leaders have picked up some nasty ideas from their American cousins. The whole society, including its police, remain much more accepting and humane toward drug users and abusers. While in London during July 1987, for example, I observed the Chief Inspector of the Drugs Branch of the Home Office taking the lead in a campaign to help an organization of injecting addicts. They were seeking to set up their own clinic where a doctor could prescribe powerful narcotics to them for maintenance. The hope was that while under the care of a doctor they would lead legal lives and eventually perhaps be helped to live without drugs.

The Great Drug War

The second set of attached recommendations is a summary of the major proposals from my latest book, The Great Drug War, 1987. That book was based upon four years of study of the current American war on drugs. In the course of that study, I traveled to some of the major fronts in our drug-control campaign and saw at first hand how it affects police, addicts, other sick people, and ordinary citizens.

The book reported on how our police are often victims of the drug war in terms of threats of violence, the temptations of easy money, and personal stress from undercover work. It reported also how people in pain and addicts, sometimes the same people, were treated as enemies in our chemical civil war and sacrificed on its martial altar.

I reviewed all available data on drugs and other threats to the health of American society. That review turned up some familiar and some new, ironic twists of reality in terms of public perceptions. The federal data for 1985, for example, documented 2,177 deaths from the most popular illicit drugs: heroin, cocaine (including crack), PCP, and marijuana. Diseases related to alcohol and tobacco killed approximately 4-500,000 Americans that year as they have in every recent year.

Federal data for 1985 showed that in the entire country, 52 children up through the age of 17 died from all forms of drug overdoses. At a time when we were being told that our children were dying in droves from crack overdoses, the book documented how federal data could identify not a single crack death (they were merged in the cocaine numbers.) The total of all known deaths from all forms of cocaine and crack abuse among children (ages 10-17) was seven in 1985. (The latest federal reports reveal that 59 children aged 17 and under died from all forms of drug overdoses in 1987.)

I also reported in the book that, after reviewing all federal data, I had yet to encounter a single overdose death due mainly to marijuana abuse. The greatest threats to children, I found, are from accidents and from the dangers of life in a modern society, often from ignored threats. Toy balloons, for example. From the files of the U.S. Consumer Product Safety Commission I was able to document a minimum of 34 deaths of children from ingestion of toy balloons between 1981 and 1985. Or swimming pools. During 1985, CPSC data recorded 337 deaths of young people (through the age of 24) in swimming pools and another 249 in swimming accidents elsewhere. Or mothers and fathers. A special computer run of FBI crime reports came up with the grisly fact that 408 American children (from infants through the age of 14) were murdered by their parents in 1983, a fairly typical year. So also the modern fast food, massive fat diet is being recognized as a major threat to the health of the nation and its children.

None of this data was meant to discount the health threat of illegal drugs. That health threat is real (and has expanded somewhat in the past few years as reflected in federal reports.) But it has been exaggerated, especially in comparison with legal drugs and other threats. Too often the health threats of illegal drugs are confused with the extra threats caused by the use of the criminal law and pursuit of the war on drugs. Those extra threats expand the basic health threat of the illegal drugs from the level of a serious problem to that of an international disaster.

The experience of working on the book outraged and scared me. I became convinced that my country, its people, democratic institutions, and human rights were in danger because our leaders had lost their sense of balance over this problem. Accordingly, I pleaded for calm and humane methods for dealing with the drug problem. I did not recommend legalization of all drugs as the answer but instead called for a bundle of peaceful compromises, in the best American tradition, that might receive practical support from Middle America.

Included in that bundle of peaceful compromises, among others, were the following proposals. Place greater controls on the sale and consumption of currently legal drugs, especially alcohol and tobacco. Place fewer controls on some of the currently illegal drugs. Put health warning labels on every container of alcohol, including beer and wine. Restrict all alcohol and tobacco advertising to agate-type listings in newspapers. Prohibit all smoking on airplanes and in many other public locations. Make marijuana use and cultivation legal for personal use by adults. Medicalize heroin and cocaine for addicts by prescription but do not make them legal for nonaddicts. Create new legal protections against the search for drugs in the homes, the lands, the bodies, and the bodily wastes of free citizens.

Initial Resolutions of The Drug Policy Foundation

My work on that book had one other impact on me. It convinced me that instead of another book, I wanted to create a new reform organization. Accordingly, starting in late 1986, with the help of a few friends, I began work on the Drug Policy Foundation. It came into formal existence in April 1987. The foundation is a reformist think tank meant to provide a rallying point for opponents of the war on drugs in America and other countries. We are now creating an enduring professional research and educational institution that will function beyond the time when this issue fades once again from the headlines. I note with pleasure that some of our advisory board members and other supporters are testifying today or are in the audience. The remainder of you are invited to sign up and become Foundation Associates.

At our first major meeting -- the International Conference on Drug Policy Reform, held in London, England, July 1987 -- we produced our first set of resolutions aimed at creating a dialogue on rethinking some of the most basic ideas about drug abuse control. Many people, including some in this room, contributed to the process of drafting and redrafting that went into the current version which is attached: "The Reform of Basic Drug Control and Treatment Policies." That is the third set of reform proposals which I commend to your attention. They will be debated and voted on by the participants in the next International Conference on Drug Policy Reform to be held in Washington, October 20-23, an event to which members of this committee and other interested parties are invited.

Those resolutions do not call for legalization of all drugs but rather recommend that the war on drugs be terminated everywhere and that peaceful experiments be encouraged in varying nations and localities that include different forms of legalization, medicalization, and decriminalization. Until major legal reforms occur, however, these draft Drug Policy Foundation resolutions recommend that existing laws be enforced in a selective and rational fashion. For example, every effort should be made to support and expand the efforts of law enforcement agencies in all countries to combat those predatory, violent criminal syndicates that traffic in drugs and other illegal commodities. However, less law enforcement attention should be paid to small dealers and simple users, who should be virtually ignored by the police unless they commit other crimes, such as robbery or burglary, or create public nuisances by interfering with normal street traffic. This is the essence of the pragmatic Dutch approach to drug law enforcement. It is also the approach that many democracies take to enforcement of the sex laws.

These three sets of reform recommendations represent the highlights of my contributions and those of some of my learned colleagues to a comprehensive theoretical framework for a much needed fundamental rethinking of our drug laws and policies. There are many other sets of sensible wide-ranging reform principles that have been set out by insightful scholars and writers over the years. To name the sources of only a few: Alfred R. Lindesmith, The Addict and the Law, 1965; Rufus King, The Drug Hang-up, 1972; Edward M. Brecher and the Editors of Consumer Reports, Licit and Illicit Drugs, 1972; the Drug Abuse Council, The Facts About "Drug Abuse", 1980; and James B. Bakalar and Lester Grinspoon, Drug Control in a Free Society, 1985.

Allow me to add one more thought. While I do not recommend it, nor do any of the above writers, I am now convinced that our society would be safer and healthier if all of the illegal drugs were fully removed from the control of the criminal law tomorrow morning at the start of business. If that happened, I would be very worried about the possibility of future harm, but less worried than I am now about the reality of present harm being inflicted every day by our current laws and policies.

BEGINNING THE PEACE PROCESS IN THE DRUG ARENA

However, there is no possibility of legalization of all drugs or even a few of them within the foreseeable future. Thus, I submit, it now makes little sense to even discuss total repeal of drug prohibition as occurred with alcohol prohibition in 1933. Rather, we can have a dialogue on the rationality of a gradual series of small steps that will, in effect, disengage forces and begin building peaceful relations in an arena torn by conflict and violence. This would be the equivalent of beginning the peace process that has been attempted in other shooting wars around the world in recent years. This process may be slow and painful but it may also be our only alternative to a more destructive drug war. Here are some of the steps we might take to begin that peace process in the drug arena.

1. Tolerance, Compassion, and Help For Users and Abusers

One prime area for discussion is the policy of Zero Tolerance, which should be alien to America and to rational police and prosecution procedures in any civilized country. For centuries, police and prosecution officials have used common sense and ethics in enforcing the law. Otherwise, all systems of law would collapse from overenforcement. Zero Tolerance means that no drug violation is ignored and all users must suffer some criminal penalty. The *National Law Journal* has just documented what many suspected: nearly three-fourths of American prosecutors surveyed reject zero tolerance (and one-fourth say marijuana should be decriminalized.) The sentiments of his law enforcement colleagues did not deter the U.S. Commissioner of Customs, who originated the policy and continues to enforce it.

We should use every strategy at our command to oppose such policies, starting with opposition to appointments of extremists to official leadership positions in the drug arena. In addition, we should encourage tolerance and compassion for users and abusers -- at the same time that we try to educate them to the dangers of drugs.

When the government mounts attacks on users or suspected users, we should encourage legal action to prevent these attacks from invading rights. The Drug Policy Foundation is now developing a Medical-Legal Advocacy Project that seeks to mobilize legal talent in opposition to assaults on users. This will involve, for example, suits for damages in cases of mass random urine testing; or injunctions to stop such intrusions as just happened with Department of Justice lawyers. Another example would be support of Employee Assistance Programs, well-established methods that emphasize confidential treatment assistance rather than exposure and disgrace.

2. Federal Leadership and Funds for Treatment

We should constantly point out to the public that users and abusers are members of our family, so to speak, and that we want to help, not punish, them. We should encourage leading police organizations and thinkers to join with reformers to mutually support a vast increase in treatment facilities for legal and illegal drug abuse.

Treatment is the one area in which positive drug legislation is possible during the next session of Congress. There are many hopeful treatment bills in the hopper, but none, to my knowledge, goes far enough. I think it might be politically acceptable to recommend that the federal government take a leadership role in demanding experiments with new treatment models supervised by ADAMHA and NIDA and fueled by a vast infusion of funds, perhaps working up to three billion dollars per year by the early Nineties. The Reagan

Administration has cut treatment funds and put the pittance remaining into state block grants. Many congressmen across the political spectrum oppose this penurious approach.

These experiments should allow for a wide array of models, including drug-free, drug maintenance, and needle exchange features. They should emphasize not just charitable treatment but also those paid for in whole or in part by the patients. Thus, all economic classes would benefit and all classes might support this legislation.

Treatment on demand for every drug abuser in need -- that would be a great compromise victory in the best spirit of America. We can accomplish that wonderful goal by the early Nineties.

Treatment on demand should should replace the war on drugs. To lead this dominant effort we do not need a drug czar, as has been proposed, but instead a competent health professional who is respected across the political and ideological spectrum. My hope is that the next president, whether Mr. Bush or [illegible]. Dukakis, recognizes that the man for the job is the current Surgeon General, the best appointment President Reagan ever made. Dr. C. Everett Koop should be reappointed by the next president and Congress should give him the funds and the mandate to turn America's best minds to the task of helping rather than destroying the addicts among us.

3. AIDS Treatment: A Special Priority

AIDS is a greater threat to our survival than all of the drugs combined. The major engine for the transmission of AIDS is the heterosexual injecting addict. Congress should stand solidly behind any proposal that promises to provide better treatment for AIDS sufferers and that might curb the spread of the disease. Properly designed drug maintenance (even those providing for medical heroin and other feared drugs) and needle-exchange programs should be advocated as essential elements in all AIDS-control strategies and bills. While it is sad to say, the AIDS threat makes for a much more compelling argument for decent treatment of addicts than a simple appeal to human compassion.

5. Medicine for Sufferers of More Traditional Diseases

Making feared drugs, such as heroin and marijuana, available as medicines for our sick people would seem to be a centrist proposal on which all sensible people could agree. (It is a good sign that some members of this committee, including the Chairman, have been listed among the supporters of the McKinney Bill that would have made marijuana available in medicine several years ago.) Because of irrational fears of encouraging recreational use by our youth and others, even this most compassionate of proposed legislation may fail in Congress within the near future. If so, then Congress could pass legislation upholding most of the existing control scheme but demanding that FDA and DEA, working together, see to it that heroin and marijuana were made available through doctors to those afflicted with cancer, glaucoma, multiple sclerosis, and other diseases who might be helped by these drugs. This availability could be part of a massive series of experiments in the control of pain and anxiety among our millions of sick people. An element in those experiments could be the more aggressive use of existing analgesics with less interference from the police.

Experimental use of any prohibited drug is allowed in medicine now, but federal officials set up impossible conditions for these experiments. Many innocent patients have died in agony from cancer or gone blind from glaucoma while waiting in vain for experimental protocols to be approved by DEA or FDA.

Powerful support for fundamental revisions in our attitudes and policies toward marijuana was contained in a historic decision earlier this month by Francis L. Young, the chief administrative law judge of the Drug Enforcement Administration. For the first time in history, to my knowledge, there has been a full review of the evidence about marijuana in medicine before an impartial judicial tribunal. The federal government and reform organizations, including the Drug Policy Foundation, presented documents and expert witnesses on all sides of the issue over a period of many months. There was vigorous cross examination and the submission of extensive briefs. After presiding over this exhaustive inquiry, the DEA official recommended that marijuana be rescheduled so that it could be used by doctors in medicine.

In reaching that decision, Judge Young reviewed the massive body of evidence and came to conclusions that, while focused on the issue of medical use, destroy many of the fundamental ideas at the base of the drug war. Examples:

*"There is no record in the extensive medical literature describing a proven, documented cannabis-induced fatality."

*"... the record on marijuana encompasses 5,000 years of human experience.... Yet, despite this long history of use and the extraordinarily high number of social smokers, there are no credible medical reports to suggest that consuming marijuana has caused a single death."

*"In strict medical terms marijuana is far safer than many foods we commonly consume."

*"Marijuana, in its natural form, is one of the safest therapeutically active substances known to man."

*"The evidence in this record clearly shows that marijuana has been accepted as capable of relieving the distress of great numbers of very ill people, and doing so with safety under medical supervision. It would be unreasonable, arbitrary and capricious for DEA to continue to stand between those sufferers and the benefits of this substance in light of the evidence..."

*"There are those who, in all sincerity, argue that the transfer of marijuana to Schedule II will 'send a signal' that marijuana is 'OK' generally for recreational use. This argument is specious."

The top officials of the Drug Enforcement Administration seem stunned by Judge Young's rational decision. If they refuse to endorse it, Congress could pass legislation to implement it and simply place marijuana in Schedule II of the Federal Controlled

Substances Act. As I said, it will also be necessary to force compassionate action from FDA so that the drug may be prescribed by American doctors when they deem it medically advisable. If Congress does not act, then what signal does that send about the level of humanity of this great nation as it enters its third century?

5. Experiments With Decriminalization or Limited Legalization

Working with police and prosecution leaders, Congress should encourage carefully researched experiments in decriminalization or de facto legalization of possession and small sales of all drugs. This is a major part of the Dutch approach and is controlled by an extensive set of written guidelines prepared by the prosecutors and police with the support of the judges. In essence, all drugs remain illegal; but peaceful users and small sellers are left alone; blatant sellers and those who are violent or connected with organized crime are arrested. The results here could be a reversal of the swamping of the criminal justice system, jails, and prisons with drug offenders, a reduction in street violence and police corruption, and greater overall efficiency for the police and the criminal justice system.

Carefully guided experiments might also take place with other models of limited legalization. The Alaskan approach might be more acceptable in some areas than the Dutch; namely, allow legalization, not decriminalization, of growth and possession of marijuana for personal use in the privacy of the home. No other drugs would be affected by this change based upon a state supreme court decision.

We might also consider variations of the new law being proposed by the Oregon Marijuana Initiative: upon the payment of a $50 annual tax, adults would be given a certificate by the county which would allow them to grow and possess a small amount of marijuana for personal use. Again, all other drugs would remain fully criminal under this model.

Experiments also should be considered that would explore the industrial and commercial uses of the marijuana plant. Hemp has vast commercial potential as a fiber for rope and clothing, among other uses. It is possible that experiments will produce strains of marijuana that have a high fiber value and a low intoxication potential. In the current martial climate, research on such developments is not possible.

6. Remember The Legal Drugs

We must continue to support enlightened action that places greater legal and cultural controls on alcohol, tobacco, and caffeine. Positive steps are taking place here -- more in the United States than any other country -- and we drug policy reformers support them. We also must emphasize that the greatest need for treatment remains in providing affordable help for legal drug abusers.

HOW MUCH DO YOU GIVE AN ADDICT?

I have not attempted to answer many of the detailed questions put to reform witnesses because, as I said, I do not now advocate full legalization. However, I am a strong advocate of drug maintenance as one among many optional treatments that should be available to addicts. In addition, I support the provision of injectable narcotic drugs and clean needles provided by doctors. Thus, I will deal briefly with questions about addict maintenance.

For many years, I researched the very questions raised by the Chairman about providing drugs to addicts. In the Parade article, those questions were: "And how much will you give an addict? A maintenance dose? They don't want to be maintained. They need to get high." Those years of research convinced me that the questions and the statements are misleading and reveal the basic misunderstandings that prevent rational consideration of new drug polices, ones that might work.

Some addicts need to get high. Some do not. Some do not want drugs at all but simply need a strong, sympathetic hand and close supervision while being detoxified. On this past Sunday, the same day that the misleading Parade article appeared, I had the joy of attending the wedding of a recovering heroin addict. He claims I saved his life because when he came to me and told me he was in trouble with heroin, I asked him what he wanted to do. He replied that he was totally out of control and that he needed to be "locked up." I immediately made arrangements and took him by the hand, as it were, and deposited him at a good psychiatric hospital. While in the locked ward, he was detoxified.

Had I suggested heroin to him, I would have been irresponsible. You are unfair, Mr. Chairman, by painting all heroin addicts with the same criminal, irresponsible brush. They are no more alike than cigarette addicts or alcoholics -- or congressmen or professors. When heroin addicts harm other people, I believe that they should be treated as criminals and punished. When heroin addicts reach a point in their lives that finds them seeking to come in from the criminal streets, society should treat them with compassion and care. That care should be inexpensive and readily available time and time again, since relapse is part of the process of cure.

The care should cover the full range of possibilities: locked psychiatric wards, drug-free detoxification, religious counseling, group therapy, out-patient psychiatric therapy, drug maintenance, and clean needles, among others. We must include drugs and needles because we do not now have, and never will have, a method for pushing all addicts off drugs immediately, even when the addict desperately wants to be rid of them. Maintenance is not surrender but recognition of realities. Properly operated maintenance programs do not kill addicts -- because none of the opiates are toxic in proper dosages -- and allow many addicts to live fairly normal lives. When an addict is "ready" to come off drugs, experienced doctors tell me that it is fairly easy to gradually accomplish that feat. But not before the patient, rather than the doctor or the police, is ready. Compassionate maintenance programs keep many addicts functioning, working, and paying taxes for years until that great day when they are ready to quit. For too many, that day never comes, but society and the patient are still better off because drug maintenance was available.

It is extremely difficult for doctors to determine the proper dosage of narcotics for any condition, including cancer pain. This is not a new issue for medicine. It is no surprise, therefore, that it is difficult to determine the proper dosage during maintenance and also to determine when an addict is actually ready to be properly weaned from powerful narcotic drugs. These questions should become some of the most important elements in the new wave of treatment experiments that the Federal Government should launch under the leadership of the Surgeon General. The questions should be dealt with by doctors in consultation with their addict-patients, nurses, and other doctors -- not by congressmen and criminologists. One of the great mistakes of American drug policy has been that politicians and police made it their business to tell the doctors how to prescribe drugs. If we are to make any progress, we must pull the government and the criminal law back from addiction treatment and let the healers debate issues of health policy.

British doctors have openly debated maintenance issues for decades. In 1924, their Minister of Health put some of the central questions to a group of leading doctors: "to consider and advise as to the circumstances, if any, in which the supply of morphine and heroin ... to persons suffering from addiction to those drugs may be regarded as medically advisable." In 1926, the Rolleston Committee issued its historic report which described two types of patients for whom long term maintenance on these powerful narcotics was considered proper and helpful. First, "those in whom a complete withdrawal of morphine or heroin produces serious symptoms which cannot be treated satisfactorily under the ordinary conditions of private practice." Second, "those who are capable of leading a fairly normal and useful life so long as they take a certain quantity, usually small, of their drug of addiction, but not otherwise."

In other words, the Rolleston Committee saw the prescription of powerful narcotic drugs not as a means of destroying normal life or of killing a worthless addict off, but rather of making it possible for an addict to survive and to lead a fairly normal life outside a hospital. This medical advice is both compassionate and ageless.

Applied to the questions put by the Chairman, it would mean that doctors would never provide drugs to patients not addicted and they would never provide such a high dosage to addict-patients that they became stuporous and unable to work or to be good family members. By implication, then, good maintenance programs should involve a social contract: we in society will see to it that you receive your drugs of addiction and clean needles legally through doctors; you, the addict-patient, must in return see to it that you function as a good citizen, employee, and family member.

Does this mean that we would allow addicts on maintenance to work as pilots on airplanes and captains of nuclear submarines? Of course not. At the same time, I realize that the greatest chemical threats to our pilots and captains are found in alcohol abuse, a problem that the current war on drugs almost totally ignores. Even if all drugs were totally legal, alcohol would still be a greater threat to transportation safety than all of the currently illegal drugs combined.

USE AND ABUSE: WILL THEY RISE DESTRUCTIVELY?

Recently, President Reagan declared that he would fight to his last breath the idea of drug legalization which he characterized as destructive and perverse. This is only the latest in a long line of abuses heaped on the proposals of those who come out for fundamental change of American drug policies. The most serious count in the indictment is often the charge that change in the drug laws is utterly irresponsible because it is certain to produce an explosion of use and abuse -- in particular among youth and poor minority groups.

We all should be concerned about the possibility of a great rise in use and abuse should the criminal drug laws be relaxed. I certainly worry about that, as should all sensible reformers. If I believed that law reform would bring a destructive explosion of use, I would rethink my position. However, my review of the evidence leads me to more comforting conclusions.

Some of my greatest comfort is found in a review of the historical record on the reports of impartial study commissions and authorities over the years. Many of them have recommended a relaxation of harsh criminal prohibition laws and experimentation with various compromise provisions allowing for greater freedom in the use of some drugs. Thus, we reformers have a good deal of rational history on our side.

This is particularly true of the record of marijuana reports. There have been at least seven major studies by impartial bodies of experts over the years in various countries. One of the most notable was The Indian Hemp Drugs Commission Report (1894) which was undertaken by British and Indian experts, who secured testimony from 1,193 witnesses from throughout the Indian subcontinent. In addition, there has been The Panama Canal Zone Military Investigations (1916-29); The LaGuardia Committee Report (1939-44) on conditions in New York City; The Baroness Wooten Report (1968) on the United Kingdom; The Interim Report of the Canadian Government's Le Dain Commission (1970); the National Commission on Marihuana and Drug Abuse, Drug Use in America: Problem in Perspective (1973); and the National Research Council of the National Academy of Sciences, An Analysis of Marijuana Policy (1982).

The congruence in basic findings of these studies spanning nearly a century is truly remarkable. None found marijuana to be harmless. All found marijuana to present some dangers to some people but concluded that the actual level of harm was consistently exaggerated and that control measures were frequently too harsh. Several of the studies stated flatly that rigid criminal prohibition laws were harmful.

The last two reports were issued by Americans and happen to be the only two major national studies performed by impartial groups of experts in our history. The report of the National Commission on Marihuana and Drug Abuse was mandated by Congress during the Nixon war on drugs and was carried out by a generally conservative commission appointed by the Republican president. After a massive series of studies of the entire illicit drug situation in the United States, the first recommendations of the commission were, to the dismay of President Nixon and many supporters of harsh drug laws, as follows:

"1. Possession of marihuana for personal use would no longer be an offense, but marihuana possessed in public would remain contraband subject to summary seizure and forfeiture."

"2. Casual distribution of small amounts of marihuana for no remuneration, or insignificant remuneration not involving profit, would no longer be an offense."

These proposals for moderate compromises have been treated with disdain by the American Congress -- but not by the prestigious National Academy of Sciences in the latest comprehensive American report in 1982. The Academy reiterated its support for the recommendations of the commission a decade earlier but then went dramatically further. It recommended that carefully prepared and researched experiments be considered that would involve removal of federal criminal penalties for cultivation and distribution of marijuana. Under this thoughtful plan, states would be encouraged to devise individual methods of control as they now do with alcohol. Thus, some states might have systems that provided for regulated sale and taxation of legal marijuana.

In making those proposals the National Research Council carefully reviewed all of the available evidence on the relationship between the proposed changes in the criminal law and the possibility of an increase in use and abuse. Some of the most important American evidence was found in the 11 states that decriminalized possession during the Seventies. The council saw that these relaxed criminal laws had no significant impact on use but that the new laws had helped curb massive criminal justice expenditures and injustices to many people. The council projected the estimate that even the more far-reaching legal distribution and sale were not likely to produce significant changes in use -- if governments, opinion leaders, and families employed sensible, non-criminal control methods.

The National Research Council placed great emphasis on building up public education and informal social controls, which often have a greater impact on personal behavior than the criminal law. The council also had these comforting thoughts for those who would expect to see disaster for our young in a change so radical as to allow regulated marijuana sales such as with alcohol: "... there is reason to believe that widespread uncontrolled use would not occur under regulation. Indeed, regulation might facilitate patterns of controlled use by diminishing the 'forbidden fruit' aspect of the drug and perhaps increasing the likelihood that an adolescent would be introduced to the drug through families and friends, who practice moderate use, rather than through their heaviest-using, most drug-involved peers."

Coming back to the present, it has become fashionable to argue (by such allegedly neutral experts as Dr. David Musto of Yale) that while alcohol Prohibition was an overall failure, especially because of the crime and corruption it engendered, in terms of public health it was a success. Support is found in such statistics as those on alcohol consumption: during the period 1916-19, per capita consumption of absolute alcohol for the drinking age population in the United States was 1.96 gallons; during Prohibition, 1920-30, it dropped by more than half to 0.90 gallons; after Repeal, during 1936-41 it went up again to 1.54.

This argument about the health-success of alcohol Prohibition during the Thirties ignores the fact that the highest periods of mass alcohol consumption were during our earliest years as a nation when popular culture and private predilections made us a nation of hard drinkers. The high point was 1830 when Americans consumed 7.10 gallons of absolute alcohol per capita! By 1871-80, it had dropped to 1.72. All of these changes took place within an atmosphere of legality. Culture is often more powerful than the law.

Today, we are benefiting from a health culture. As a result, per capita tobacco use has been dropping dramatically recently. The percentage of smokers in the general population dropped from 41.7 percent in 1965 to 32.6 percent in 1983. And all the time, tobacco was fully legal.

On the other side of the coin, during the past twenty years we have had periodic explosions in use and abuse of, successively, marijuana, heroin, cocaine, PCP, and crack. In regard to most of these drugs, explosions in use were followed by periodic downswings. And all the time, each had been illegal. Culture and mass popular tastes again were more powerful than the law.

If, then, we implement reforms in laws or enforcement practices, we must also continue and enlarge programs of school and parental involvement in drug control. Teachers and parents have more impact on curbing drug abuse than police and jailers. Similar positive thoughts apply to ministers and treaters, especially if we invest in the recommended new array of treatment facilities.

Were the current system working so as to curb drug abuse and AIDS, I would hesitate to recommend changes. It is not working. On balance, the possibility of an overall gain in control of crime and of drug abuse from all types of drugs and alcohol outweighs the risk of an explosion in abuse of the illegal drugs.

CONCLUSION

Now is the time for bold experiments in the best American tradition. We are a nation of risk takers whose ingenuity has seen to it that we win more often than we lose when we take an intelligent chance. We have a choice of following failed policies or striking out toward new frontiers. The politically familiar paths will certainly lead to a situation where our streets will continue to be awash with crime and violence, our prisons will burst even more at the seams, the rights of all will be further diminished, and drug abuse will remain rampant. New policies give us an excellent chance to reverse those dire predictions.

From Arnold S. Trebach, The Heroin Solution,
Yale University Press, 1982

VII

Finally, here are the ten major findings and recommendations of this study.

1. *The problem of heroin addiction has taken on the dimensions of a worldwide epidemic and is worsening.* The same is true of other forms of drug abuse. The entire scene is far worse than when I started this inquiry in the early 1970s; more countries are involved, and in the countries already involved, heroin abuse has spread to all classes of society.

2. *Despite the growth of the problem, social policy cannot regress to the antiopium stone age. We must distinguish, moreover, between the encouragement of drug-free personal life-styles and the imposition of a prohibitionist public policy.* Nothing is wrong and much is right about trying to ban all drugs, legal or illegal, from one's own life and from that of one's family; everything is wrong with trying to impose such a personal philosophy on the rest of society or the world. That has been the major mistake of American (indeed, Western) policy in this century. The nonmedical use of drugs has increased dramatically despite a worldwide pattern of legal prohibition on such use. The gap between the laws, on the one

hand, and the actual behavior of millions of people, on the other, must be bridged in a rational and compassionate fashion.

3. *Some of the most compassionate bridges ever built over the chasm between addiction control policy and individual human needs were those of the British system during the Rolleston era and American counterparts such as the Shreveport clinic.* Rolleston and Shreveport, both middle-level compromises, accepted the reality of laws restricting many drugs to medical uses and of the existence of multitudes of people who were quite eager to violate those laws. They provided a way for those who sought help to come in out of the criminal cold into the warmer arms of legitimate medical practice. This did not satisfy the ultraliberals, who wanted all drugs to continue to be freely available to anyone with the purchase price; nor did it satisfy the ultraconservatives, who viewed providing drugs to addicts purely to satisfy their cravings as beyond the bounds of legitimate medical practice. In the actual field of social and human conflict, Rolleston and Shreveport worked. Those who deny this powerful reality, and there are many who do, are simply mistaken.

4. *In this context, medical heroin for addicts makes eminent good sense.* And only in this context. Heroin is important in dealing with heroin addicts because it is their drug of choice, and many of them must have the drug in order to stay in treatment and out of agony. In and of itself, however, medical heroin is not *the* solution to the worldwide heroin addiction epidemic.

5. *There is no reliable scientific evidence that heroin propels its users to criminal activity or causes organic damage.* Putting aside the problem of addiction, the chemical heroin seems almost a neutral or benign substance. Taken in stable, moderate doses, it does not seem to cause organic injury, as does alcohol over time, nor does it seem to push people into crime by making them aggressive, as do alcohol and PCP and amphetamines. At the same time, the evidence seems compelling that once a person is addicted to heroin, he has a greater tendency to become involved in criminal activity of all kinds—more and more of it, these days, violent. This increased crime is caused mainly by the legal prohibition of the drug rather than by its pharmacological impact.

6. *There is no evidence that heroin is an ineffective medicine, nor unequivocal scientific proof that it is a better analgesic than, say, morphine.* Ever so slowly, the law enforcement and medical establishments are moving toward acceptance of heroin as a medicine. As this book was being brought to a close, their position had become this: that while heroin was certainly a medicine, it was no better than others currently available, and that its bad name and its possible use by addicts made it an undesirable substance to have in ordinary American medicine. Nevertheless, this position provided evidence that a historical process was

commencing: heroin was slowly being divested of its demonic qualities. At the same time, its heroic qualities could not be demonstrated by scientific means; those had to be found in the perceptions of patients who were provided with it in order to ease the agony of organic pain or the pressures of addiction. Because some patients believe they may be helped greatly by the medicine, and because there is no indication that, when properly administered, heroin causes harm, the current legal prohibition should be repealed.

7. *Heroin should be made available, by new laws or court decisions, to all patients under the care of a doctor, not only to the terminally ill.* That part of the heroin legalization movement in America which focuses only on the terminally ill is well intentioned but misguided. The Madigan Bill, for example, introduced into Congress in May 1980, would unwittingly produce both ghoulish and impractical results. This bill would require a certification that the patients were indeed dying; once so certified, they could get their heroin. Most terminal cancer patients need no powerful narcotics at all; many burn patients need them desperately. Is a lung cancer patient more worthy of help than a cardiac patient—especially when the evidence is strong that personal habits contributed to the onset of the disease in both instances? When is a cancer patient "terminal"? Such questions have no easy answers and show the ethical impossibility of proposals to make heroin available *only* to the terminally ill. The choice of this medicine or another must be made only by the patient (or the relatives, where necessary) and the doctor on the basis of intimate and private discussions.

8. *Federal and state laws should be pulled back to the perimeters of the addiction problem. Doctors and other members of the helping professions should be encouraged to move, en masse, back into the center arena, where one of the primary functions of the guardians of the law will be to protect the helpers, not harass them.* The legalization of drugs for addicts, where appropriate and necessary, is important. Even more important is the creation of a legal structure and related enforcement practices that, together, assure doctors and other treaters that the law will allow them to try every rational approach, from temporary heroin therapy to traditional psychotherapy, oral methadone, Zen Buddhism, transcendental meditation, and opium. In cases where there is some doubt as to the good intentions of the treaters, the issue of criminal intent should be resolved in their favor. Only where the most extreme behavior takes place, clearly violating the new boundaries of legitimate medical practice, should the powers of the law be invoked.

For America, and for other countries following its lead, these may be the most important set of reforms for the immediate future. This legal structure does not mandate the use of one drug as opposed to another, or one modality exclusively, to treat addiction. Rather, it recognizes the need for healers to be allowed to heal as the situation demands, to pursue that impossible balance of treatment that will vary from patient to patient, from community to community, from time to time. If the criminal law moves back, far back, then a humane sense of rational and flexible treatment should take its place.

9. *Social policy in the future should devise methods to help people both to use drugs in beneficial ways and to create a new ethos of higher consciousness that goes beyond drugs*. If the previous recommendation was the most important, then this one is the most difficult. The task of creating rational legal and medical policies toward *addicts* is herculean; to create such policies in regard to *recreational users* and in regard to the related beneficial use of potentially addicting drugs may be beyond even the powers of the gods. This task may not be accomplished within our lifetimes. But the basic conceptual groundwork should be laid. More immediate and practical efforts, however, should focus on policy toward the addicted.

10. *The major thrust toward reform must come from coordinated national, as well as multinational, legal and political action*. This is not to suggest that scientific research and academic conferences should cease. It is to say, rather, that the basic technical issues have changed very little in decades. The major practical impact, during those years, has been made by ideology, political action, and legal enactments. Most objective scientific research has had little practical effect. In the face of growing fears about drug use and abuse, it is time for concerted action. To those who agree, here are a few brief suggestions for such action.

In Britain

- Mount a campaign to widen the involvement of private doctors in addiction treatment and also to revive some of the clinical practices of the Rolleston era, especially the more liberal medical dispensation of heroin and cocaine to addicts. This may be accomplished by amending the Misuse of Drugs Act or simply by having the home secretary issue more licenses to physicians to dispense those "restricted drugs" to addicts.
- Launch organized political-medical efforts to reduce the dominance of the drug-dependence clinics.

In America

- Public-spirited lawyers should take the lead in developing a legal assault on the restrictive legal control of medical practice in regard to opiates and addiction treatment. Enlightened physicians and other healing professionals should provide technical support for this legal reform effort.

- In some cases, legislative reform proposals will make practical sense. But in most matters, especially in regard to heroin and addiction treatment, the legislative route to reform may fall victim to popular prejudices. As in the civil rights efforts of a generation ago, the only realistic route may be court action.
- Court action must be taken to free up heroin for widespread use in medicine, either by placing it in Schedule II of the Controlled Substances Act of 1970 or by having it placed, like methadone, in a special investigational category for widespread experimentation.
- Such lawsuits must also be instituted to make any narcotic and cocaine available for use in treatment, unless it has been shown that the drug is organically harmful.
- The detailed intrusion of federal laws and administrative regulations into the treatment of addiction must be fought at every turn by court action so as to open up working room for innovative physicians—and thus to expand along British lines the concept of legitimate medical practice.

In Other Countries

- Drug control systems must be developed—with the prodding of lawsuits, where necessary—that fit the cultural contours of each nation. If, however, foreign models are needed, they should be sought in the Shreveport clinic of 1919–23 in America, the Rolleston era up to 1968 in Britain, and the American system we here dream about.

From Arnold S. Trebach, The Great Drug War,
Macmillan Publishing Company, 1987

Epilogue: My Proposals in a Nutshell

1. Stop talking about winning drug wars. In the broadest sense, there is no way to win because we cannot make the drugs or their abusers go away. They will always be with us. We have never run a successful drug war and never will. Our goal should be the fashioning of those methods of living peacefully with drugs that create the least possible harm for users and their nonusing neighbors.

2. Recognize that the line between illegal and legal drugs is a historical accident based primarily upon emotion rather than science. All drugs—including alcohol, tobacco, heroin, cocaine, PCP, marijuana, and many others—are dangerous. At the same time, all can be used in relatively nonharmful ways by many people.

3. Start thinking about drugs and abusers in new ways. Think drugpeace instead of drugwar. Think of drug addicts as potentially nice neighbors with a distressing problem instead of inherently evil criminals intent on robbing you because the drugs they take drive them crazy.

4. Protect our sick from the ravages of the drug war. They are its saddest victims. The great majority of them are innocent of any involvement with crime or the drug trade. If they are organically ill and suffering from diseases such as cancer or glaucoma, then

heroin and marijuana should be made available to them by prescription. If they are suffering from the disease of drug addiction and are dependent on heroin or cocaine, then those drugs should be made available to them by prescription. If they are injecting addicts, they should be provided with clean needles.

5. Demand of addicts in return that they live productive and noncriminal lives. Thus the social contract we make will be legal drugs in return for legal, loving lives. If some addicts continue to ignore their legitimate jobs, their loved ones, and the law, the deal, for them, is off.

6. Protect society from the ravages of the drug war—from criminal traffickers, from criminal drug addicts, and from criminal police and prosecutors. Much of this will be accomplished by reshaping our thinking and our laws concerning drugs, as was the case during Prohibition. Where the legal reforms do not automatically accomplish these happy results, we should add specific requirements, such as the contract with addicts.

7. Provide affordable treatment of all kinds as often as needed to everyone suffering from the disease of drug addiction. Tobacco addicts and alcohol addicts are drug addicts according to my definition. They will be harmed, not helped, by continuing to use their drug of dependence, unlike some narcotics addicts. All of these millions of people need treatment. It is not simply a case then of feeding drugs to addicts but of developing a network of treatment experts and facilities that meet the individual needs of each addict.

8. Curb the excesses of the venal elements of the drug-treatment business. The future of much of the new treatment network will come from the private sector. Yet too many of our leading experts, including prestigious physicians, are abusing and stealing from the public by locking up people needlessly and charging obscene fees. These medical jackals must be controlled and the best elements of the treatment profession encouraged to step in and help the addicted.

9. Convince the police that they are among the saddest victims of the drug war and that they should be in the leadership of the reform movement. In that role, they can be very effective. It is the equivalent of a conservative, communist-hating President making peace with a leading communist nation. This is not a fantasy. Remember President Nixon's historic initiatives with Red China.

10. Making peace with drugs and drug users is not the same as surrendering. (We did not surrender to Red China.) A peaceful

drug scene does not require the abolition of all drug laws but the creation of more sensible, more effective ones.

11. Give the police the financial, legal, and moral backing to escalate their courageous work against major organized-crime syndicates. If we reform drug laws, these social jackals will turn their attention to other illegal activities where they will continue to be major threats.

12. Back the federal government out of direct control of drug problems. Give the states primary responsibility. That is the compromise we devised to escape from the disaster of alcohol prohibition.

13. Create a bundle of peaceful compromises that will receive support from Middle America. Place greater controls on the sale and consumption of currently legal drugs, especially alcohol and tobacco. Place fewer controls on the currently illegal drugs. Examples: put health warning labels on every container of alcohol, including beer and wine; restrict all alcohol and tobacco advertising to agate-type listings in newspapers; prohibit all smoking on airplanes and in many other public locations; make marijuana use and cultivation legal for personal use by adults; medicalize heroin for addicts and pain patients by prescription but do not make them legal for casual recreational use.

14. Create new legal protections against the search for drugs in the homes, the lands, the bodies, and the bodily wastes of free citizens. Treat those drug warriors who want to display their own bodily wastes and to look at the wastes of others with the disgust they deserve.

Revised Draft B
December 1987

THE REFORM OF BASIC DRUG CONTROL AND TREATMENT POLICIES

Beginning Proposals

First Set of Resolutions
of the
Drug Policy Foundation

Drafted Originally at the
International Conference on Drug Policy Reform
Imperial College of Science and Technology
London, England
July 1987

These are draft resolutions that have not yet been approved by the board of advisors of the Drug Policy Foundation. They are in the process of revision. Written comments from all interested parties are welcome. Send them to The Drug Policy Foundation, Suite 400, 4801 Massachusetts Avenue, N.W., Washington, D.C. 20016.

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INTRODUCTION

The Drug Policy Foundation was created in 1987 out of a conviction that a new centrist institution was desperately needed in the drug arena. It provides an educational and research forum for exploring rational policy options within individual countries and on the international scene. The first meetings of the foundation were held in London, England during July 1987. Over one hundred people from thirteen countries attended two conferences that marked the beginnings of a new international drug policy reform movement.

During the course of those meetings, a set of resolutions was drafted that sought to rethink some of the most basic ideas determining how societies, governments, and individuals should think about fundamental issues of drug control and treatment. Even though most of those present considered themselves drug war opponents and policy reformers, they soon came to see that agreement on a new model code of basic policies would take considerably more time than was then available. It was decided that the resolutions would be redrafted and circulated for more extended discussion and comment by the advisory board and other interested parties.

On the basis of comments from a number of experts, the original London draft was rewritten. That draft, dated November 1987, became the basis for extended discussion at the meeting of the advisory board in Washington, D.C. on November 20, 1987. This revised draft was the result of the board's deliberations that day. The board decided that it would seek to place first priority in these resolutions on defining the common ground that might unite the great majority of drug policy reformers. While some people might view many proposals here as extreme, the board views them as etched in the middle ground of rational policy options. In time, the Drug Policy Foundation and its friends hope to convince a majority of citizens that these resolutions are indeed moderate and rational.

The Board of Advisors of the Drug Policy Foundation will soon review all of these comments, vote, and issue a final version of this new model code. Members may issue concurring and dissenting opinions. The foundation views this effort as only the first of many attempts to issue statements that seek to redefine drug policies. Because this set deals with the most basic ideas, it may prove exceedingly difficult to achieve a broad consensus. However, the very process of debate by all concerned may prove a most beneficial exercise. In the view of the DPF, dominant drug policies -- especially those upon which drug wars and massive use of the police and the military are based -- are so harmful and yet so imbedded in the ideological foundations of our society that only the most painful rethinking process has any hope of digging them out and bringing them to light.

FACTUAL BACKGROUND

1. Current drug control policies often have been ineffective in stopping millions of people throughout the world from using and abusing drugs, legal and illegal. Since the advent of near-total prohibition of the use of many drugs, in some countries there have been dramatic increases in the number of people using such substances as cannabis, amphetamines, heroin, and cocaine.

2. The governments of most nations seem oblivious to past lessons of drug and alcohol control campaigns, especially the fact that what are often identified as drug problems are in fact the costs of prohibition policies. Some of those costs are: black markets, organized crime, official corruption, violence in the drug trade, crime by addicts seeking money to buy expensive drugs, and impure drugs that harm users. While there is some evidence that prohibition has at times been accompanied by a reduction in the number of users -- as during alcohol prohibition in the United States -- that result is not always certain. Moreover, during prohibition, the American leadership concluded that while alcohol was a terribly destructive drug, the overall costs of prohibition were worse for the society.

3. While treatment facilities have increased in recent years, in many countries there remains a great shortage of effective treatment programs which are available and affordable to all who need it, whether suffering from addiction to legal or illegal drugs. Much drug and alcohol treatment has been of doubtful value and some quite harmful. Treatment options, such

as those involving maintenance of addicts, have often been limited by political considerations.

4. Current legal and enforcement policies tend to drive many users of banned substances underground and into a clandestine life-style. As a result, they become alienated from the effective delivery of primary health care. Enforcement policies also may have contributed to the growth in the practice of injecting drugs, partly due to pressures that encourage traffickers to ship drugs in more concentrated forms. At the same time, with some exceptions in the United Kingdom and the Continent, dominant policy restricts the access of addicts to clean needles. Because intravenous drug use has been a major route for transmission of the AIDS virus, current drug control policies thus may well have contributed to the spread of AIDS.

5. Drug control policies have resulted in vast price increases for chemical substances that are not intrinsically expensive. Indeed, many illegal drugs are now more valuable, ounce for ounce, than gold. In the light of the huge worldwide demand for these valuable commodities, a rich market involving staggering profits has been created for organized crime. Hundreds of billions of dollars have been accumulated in the illicit market. The economic power of organized criminals competes with that of law-abiding businesses and, in some countries, with that of the national government itself. The corrupting influence of narcodollars threatens the stability and integrity of those governments.

6. The heavy reliance on the criminal law and the police to curb participation in this vast market has brought intolerable pressures upon the institutions of criminal justice and the human beings who work in them, especially the police. The lure of corruption is an ever present risk; so is violence from traffickers. There is also great pressure to ignore constitutional freedoms and personal privacy because drug suspects are portrayed by leading officials as beneath ordinary respect. Control of other criminal violations is often overlooked. In large measure due to drug arrests, many national prison systems are becoming extremely overcrowded. That of the United States, for example, increased a record 73 percent during the Reagan Era when the prison population went over 500,000 for the first time in American history.

7. Constitutional rights and democratic traditions are being invaded in the name of saving the nations of the world from the drug menace. Homes and human suspects are being searched under conditions and circumstances heretofore thought intolerable. Mass random urine and blood testing of millions without reasonable suspicion or cause is becoming accepted

procedure. Unprecedented powers to combat money laundering have brought enormous police intervention in many of the regular activities of business, finance, and international trade.

8. Harsh prohibitionist policies and the imprisonment and even execution of those involved with certain drugs often have been justified around the world in large part as the only methods for protecting youth from the allure of destructive chemicals. Yet, there have been dramatic rises in youth drug use while these policies were in place. Extremist antidrug propaganda has sometimes had the effect of spreading interest in new drugs among the youth of the world. Such widespread publicity has often attracted youth to drugs as a means of defiance of authority. It is also important that we realize that a major theme in the successful campaign of sixty years ago to end American alcohol prohibition was that repeal was necessary to save families and children from the chaos, crime, and dishonesty that prohibition bred.

9. Some valuable medicines have been denied to sick people because authorities fear that the drugs will be diverted from hospitals to the streets. Heroin and marijuana, for example, are prohibited from medical use in most countries of the world. As a result, drug war ideology interferes with the practice of medicine and causes suffering to innocent patients -- afflicted by such diseases as cancer, glaucoma, and multiple sclerosis -- who have nothing whatsoever to do with recreational drug use or crime.

10. Relations between nations are strained because they accuse each other of being to blame for each others' drug problems. The United States, for example, is determined to penalize nations in which illicit drugs are produced for the American market. However, leaders of each nation must understand that the drug problem is rooted in the desires of millions of their own people for the regular use of mind-altering substances and not in the actions of foreigners. With perhaps a few exceptions, moreover, there is little evidence that the planned, official policies of any nation have ever effectively stopped use of any drug for any significant length of time among its people. The same verdict of historical impotence applies to interdiction of domestic and international drug trafficking by governments working alone or together.

11. Drug use and, sadly, drug abuse will ever be powerful presences among the peoples of the world. The greatest controls on these practices have always been found in personal, familial, religious, social, and cultural forces. Governments, armies, and police forces can exercise controls

only at the edges of these practices. It is unrealistic to expect official controls to work in place of personal and cultural controls. The withdrawal of official force to the perimeters of the problem may well have the impact of increasing the effectiveness of the best controls.

RESOLUTIONS

1. Fundamental revisions in public attitudes and official policies are necessary if the nations of the world are to stop their destructive pursuit of the drug war and to commence the painful process of thinking out more effective and more humane ways for dealing with drug use and the drug trade.

2. The governments of the world should stop talking about launching and winning drug wars. Indeed, the very concept of a war on drugs, either in one country or throughout the world, is a destructive idea. Wars imply intolerance and hate. The essence of our approach to all of our citizens, whether or not they use disapproved chemicals, should be tolerance and respect. The goal of all nations should be fashioning policies that create the least possible harm for users and their nonusing neighbors. Thus, the war on drugs should be declared terminated, everywhere.

3. Until major legal reforms occur, however, existing laws must be enforced in a selective and rational fashion. For example, every effort should be made to support and expand the efforts of law enforcement agencies in all countries to combat those predatory, violent criminal syndicates that traffic in drugs and other illegal commodities. However, less law enforcement attention should be paid to small dealers and simple users, who should be virtually ignored by the police unless they commit other crimes, such as robbery or burglary, or create public nuisances by interfering with normal street traffic. This is the essence of the pragmatic Dutch approach to drug law enforcement. It is also the approach that many democracies take to enforcement of the sex laws.

4. Because drug abuse problems vary considerably from locality to locality, great flexibility should be provided for nations and regions of nations to experiment with different methods of control and treatment. Setting controls on drugs does not require strong uniform rules as in the case of international aviation and electronic communication. A number of examples from history suggest the value of local solutions; for example, the British system of allowing individual doctors almost complete freedom in the treatment of addicts and the American repeal of alcohol prohibition by allowing each state

to choose its own policy on recreational use. Current failures of established national and international strategies suggest that the need for new ideas is urgent. Thus, experimentation should be encouraged. This could appropriately include the legalization of some drugs, such as marijuana, and their sale through regulation and taxation schemes.

5. Great emphasis in these experiments should be placed on devising new techniques for building personal, social, and cultural means of controlling drug and alcohol misuse or abuse. Such techniques should take precedence over those that employ official power, the police, the criminal law, and prison cells. A major element in this new drive to build noncriminal controls will be honest education and information programs. Since so much of the scientific data on drug abuse is subject to honest debate, authorities should admit the existence of the conflict of expert views and present all sides to the public. Thus, governments would cease the current practice of choosing one side in the debate on a particular drug and declaring it to be the complete scientific truth.

6. Another essential element in more effective drug abuse control strategies would be a vast number of experiments that would offer a full array of affordable or free treatment programs for anyone in trouble with a legal or illegal drug. The choice of treatment regimes should be a confidential matter between treater and patient. The criminal law and the police should keep a respectful distance. Legal and ethical options for the treatment of drug and alcohol abusers should include those based upon such concepts as detoxification and abstinence, religion, therapeutic communities, traditional psychiatric and social work counseling, and drug maintenance. None of these programs should be mandated for all addicts; none should be forbidden. All of these treatment programs ought to operate on the principle of harm reduction, not on the theory that all users can be made drug free.

7. We should commence thinking of drug addicts as basically decent neighbors with distressing problems rather than as enemies in a war who are bent on our destruction in part because the drugs they take rob them of moral restraint. A narcotic addict may be given long-term drug maintenance treatment when, as recommended by the British Rolleston Committee in 1926, (1) withdrawal of the drug creates such distress that hospitalization is required, or (2) the patient can lead a fairly normal life on a regular dose of the opiate but not without it. The choice of maintenance drugs should be a medical decision, made in consultation with the patient. Most known narcotics should be allowed in maintenance; this includes heroin, methadone, morphine, codeine, and Darvon, among many others. The form of the drug may be oral or injectable. When the latter, the patient should be provided

clean needles and instructions for healthy injecting, which should curb many ailments -- not least the spread of AIDS.

8. No drug should be denied an organically ill patient for any reason, including fear of diversion to street addicts. Thus, the law should be amended in those countries that prohibit, for example, heroin and marijuana in medical treatment. The DPF notes with approval the humane practice in the United Kingdom of permitting the relief of suffering of the organically ill with a wide range of pain killers, including heroin. The foundation also applauds the recent decision of Canada to permit the use of heroin for the treatment of pain in that country once again. In a similar vein, currently legal medicines should not be denied to patients, especially those seriously ill or in great pain, because of fear of addiction or diversion to criminal addicts.

9. Greater attention at all levels must be paid to alcohol and tobacco, which create the greatest problems for the people of most nations. Civil, as opposed to criminal, laws and social mores should be adjusted to impose greater controls on the use and abuse of these drugs. The design of new treatment facilities must take into account that these drugs, and not the currently illegal ones, create the largest numbers of abusers in urgent need of help.

10. Civil liberties, democratic traditions, and simple common sense must not be sacrificed in the process of enforcing the drug laws. Searches of human beings, whether of bodily cavities or tissues or fluids, must never be performed without reasonable grounds or suspicion. Random searches and testing of free citizens should be universally condemned. So also should be the practice of banning decent, competent workers from jobs because of the present contents of their bodily fluids -- or, as in the case of a recent American Supreme Court nominee, because of past drug use.

11. The DPF affirms the ancient legal precept that a criminal should not be permitted to enjoy the fruits of his crime. However, it opposes new laws and prosecution practices in pursuit of this precept that push forfeiture powers to their extreme. These practices include rapid and wholesale confiscation of funds and property of drug suspects before a conviction has been achieved, thus violating the presumption of innocence. Often, this interferes with the right to counsel -- as when the forfeiture takes place after the suspects have paid attorneys fees and the funds are in the possession of their lawyers. The foundation also opposes assaults on the integrity of those lawyers with the temerity to accept drug defenses and to pursue them in accord with their professional oaths. It applauds the work of the bar in defending drug cases as often

being supportive of the very foundations of civilized jurisprudence.

12. The Drug Policy Foundation shares the concerns of millions of parents throughout the world that their children might be endangered by the misuse of drugs. The answer, to the extent there is one, is not to call for greater use of the criminal law nor is it, as some leading American officials have done recently, to call for the arrest and imprisonment of our drug-using children as a new, and strange, form of love. The answer lies more in seeking to strengthen traditional family and cultural controls and to develop better techniques of compassionate treatment for young drug abusers -- mainly outside of locked institutions.

13. It is unlikely that major reforms can advance around the world in the restrictive climate created by most international drug control treaties and by the official policies of United Nations drug control agencies. With some exceptions, they are dominated by ideas and people securely attached to current failed policies. However, the DPF acknowledges the values of the international control system to the extent it prevents drug manufacturing companies from overproducing certain drugs and limits availability from such sources. Reforms must be made in international treaties that prevent nations from legalizing certain drugs and which in other ways inhibit reform experiments. Moreover, personnel of international drug agencies must in the future include those capable of encouraging such enlightened experiments.

14. Official international conferences on drug control, such as the United Nations meeting held in Vienna during June 1987, should provide ample time for considerations of major peaceful changes in treaties and practices. The delegations from each country should include experts with a wide range of views, including advocates of peaceful drug policy measures. The foundation notes with regret that the United States delegation to the Vienna meeting was composed almost exclusively of officials with an extremist viewpoint who advocated an expansion of the drug war. Such extremism causes harm to national images and interests and contributes nothing to the cause of controlling drug abuse anywhere in the world.

These resolutions are only a start. They are an initial attempt to outline the basis for effective, humane drug abuse control policies. The guiding principles must be moderation, temperance in the true sense, the reduction of harm, the amelioration of unhealthy practices -- and the willingness to experiment with new ideas. In that spirit, we of the Drug Policy Foundation assure our friends, colleagues, and opponents that these proposals are not embedded in concrete. They have been drafted only after a great deal of agonizing and intellectual sweat. We ask you to join us in this demanding but worthwhile effort. In what way are they impractical? How might they be improved -- in terms of the international situation or in terms of the particular needs of a specific nation?

Written comments from all interested parties are welcome.
Send them to:
The Drug Policy Foundation
Suite 400
4801 Massachusetts Avenue, N.W.
Washington, D.C. 20016.

Telephone 202-895-1634

AST 12-1-87

TESTIMONY OF

ADMIRAL JAMES D. WATKINS

U.S. NAVY (RETIRED)

FORMER CHAIRMAN OF THE PRESIDENTIAL COMMISSION
ON THE
HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC

BEFORE THE

HOUSE SELECT COMMITTEES ON NARCOTICS

"LEGALIZATION ILLICIT DRUGS --
IMPACT AND FEASIBILITY"

THURSDAY, SEPTEMBER 29, 1988

WASHINGTON, D.C.

THANK YOU, MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE FOR INVITING ME TO PARTICIPATE IN THIS IMPORTANT DISCUSSION ON DECRIMINALIZATION OF ILLEGAL DRUGS.

AS YOU KNOW, ON JUNE 24, THE PRESIDENT'S COMMISSION ON THE HIV EPIDEMIC ISSUED ITS REPORT MAKING RECOMMENDATIONS TO THE PRESIDENT ON ACTIONS NECESSARY TO COMBAT AIDS.

THE COMMISSION CONDUCTED 45 DAYS OF IN-DEPTH HEARINGS, COLLECTING INFORMATION ON THE EPIDEMIC FROM EXPERTS THROUGHOUT THIS NATION.

VERY EARLY IN OUR DELIBERATIONS, THE COMMISSION REALIZED THAT THE HIV EPIDEMIC WAS INEXTRICABLY INTERTWINED WITH THE DRUG ABUSE EPIDEMIC. SEVERAL OF OUR COMMISSIONERS ASKED: "ARE WE THE AIDS COMMISSION OR THE DRUG COMMISSION?" SOME STATISTICS SHOULD ILLUSTRATE THIS POINT. INTRAVENOUS AND OTHER DRUG ABUSE IS A SUBSTANTIAL CONDUIT OF HIV INFECTION, A MAJOR PORT OF ENTRY FOR THE VIRUS INTO THE LARGER POPULATION.

ALTHOUGH INTRAVENOUS DRUG ABUSERS CONSTITUTE ONLY 25 PERCENT OF THE AIDS CASES IN THE UNITED STATES, 70 PERCENT OF ALL

HETEROSEXUALLY TRANSMITTED CASES IN NATIVE-BORN CITIZENS COMES FROM CONTACT WITH THIS GROUP. IN ADDITION 70 PERCENT OF PERINATALLY TRANSMITTED AIDS CASES ARE THE CHILDREN OF THOSE WHO ABUSE INTRAVENOUS DRUGS OR WHOSE SEXUAL PARTNERS ABUSE INTRAVENOUS DRUGS. AND THE SITUATION IS RAPIDLY WORSENING AS THE NUMBER OF INFECTED DRUG ABUSERS GROWS DAILY.

IN ADDITION TO THE DIRECT THREAT OF TRANSMISSION FROM NEEDLE AND PARAPHERNALIA SHARING, THE COMMISSION WAS REPEATEDLY TOLD THAT ALCOHOL AND DRUG ABUSE IN ALL THEIR MANIFESTATIONS IMPAIR JUDGMENT AND MAY LEAD TO THE SEXUAL TRANSMISSION OF HIV.

AFTER EXTENSIVE HEARINGS ON THE LINK BETWEEN DRUG ABUSE AND HIV, SEVERAL THEMES EMERGED. FIRST, THE DRUG TREATMENT SYSTEM IN THIS NATION IS SERIOUSLY INADEQUATE ESPECIALLY IN AN ERA OF AIDS. WITH AN ESTIMATED 1.2 MILLION INTRAVENOUS DRUG ABUSERS, AT ANY GIVEN TIME NO MORE THAN 148,000 ARE IN TREATMENT. THIS LACK OF TREATMENT AVAILABILITY LED THE COMMISSION TO CALL FOR A MASSIVE LONG-TERM COMMITMENT TO TREATMENT AVAILABILITY. IT WAS NOT FOR PURELY ALTRUISTIC REASONS BUT TO STOP THE RAMPANT

SPREAD OF THE HIV BY GETTING PEOPLE TO STOP USING DRUGS.

EQUALLY IMPORTANT, HOWEVER, WAS THE REPEATED CALL BY OUR WITNESSES TO SEEK A CHANGE IN SOCIETAL ATTITUDES WHICH PERMIT DRUG ABUSE. THEY IMPLORED US TO INSPIRE LEADERSHIP BOTH NATIONALLY AND LOCALLY TO CREATE DRUG FREE COMMUNITIES, URGING SPECIAL ATTENTION BE GIVEN TO PREVENTION PROGRAMS. HELPING OUR YOUNG PEOPLE TO AVOID ABUSING DRUGS IN THE FIRST PLACE IS ONE ESSENTIAL INGREDIENT TO THE SURVIVAL OF OUR DEMOCRACY.

WHAT IS NEEDED ACCORDING TO ALL THE EXPERTS IS A COORDINATED FULL-SCALE EFFORT WHICH ADDRESSES BOTH SUPPLY AND DEMAND, WITH EQUAL ATTENTION TO PREVENTION, EDUCATION, TREATMENT, RESEARCH, INTERDICTION, ERADICATION AND FULL ENFORCEMENT OF OUR CRIMINAL LAWS.

IN A DISCUSSION ANALOGOUS TO THE ONE WE ARE HAVING TODAY, VOICES WERE RAISED SEEKING THE PROVISION OF CLEAN NEEDLES FOR ADDICTS AS A MEANS FOR CURBING THE SPREAD OF THE HIV EPIDEMIC.

I RAISE THIS ISSUE BECAUSE MANY PEOPLE FEEL PROVISION

OF CLEAN NEEDLES BY GOVERNMENT SANCTIONED PROGRAMS IS THE FIRST STEP TOWARDS ACTUAL GOVERNMENT SANCTION OF THE USE OF ILLEGAL DRUGS. THE HIV COMMISSION HEARD EXTENSIVE DEBATE ON THIS ISSUE.

EARLIER THIS YEAR, THREE OF MY FELLOW COMMISSIONERS AND I ATTENDED MEETINGS AT HARLEM AND METROPOLITAN HOSPITALS IN NEW YORK. WE SPENT TWO DAYS WITH REPRESENTATIVES OF 22 CHURCHES IN THE REGION, SEVERAL SENIOR BLACK OFFICIALS, AND THE SPECIAL NARCOTICS PROSECUTOR FOR THE FIVE BOROUGHS OF NEW YORK CITY. THEY HAD MUCH TO TELL US. ALL SAID THAT I.V. DRUG ABUSE WAS KILLING THEIR COMMUNITY, AND ALL WERE BITTERLY OPPOSED TO NEEDLE EXCHANGE AS A MEANS OF DEALING WITH THIS PROBLEM.

WHY? BECAUSE THEY VIEW CLEAN NEEDLE PROGRAMS AS A COP OUT. THEY SEE THEM AS DIVERSIONARY TACTICS THAT ONLY MISLEAD THE UNINFORMED THAT CHEAP, QUICK MECHANICAL FIXES CAN SOMEHOW WORK THEREBY AVOIDING MORE COSTLY ALTERNATIVES. AT BEST, THEY VIEW SUCH PROGRAMS AS STOP-GAP MEASURES THAT WILL FAIL TO GET ADDICTS INTO TREATMENT, FAIL TO STOP THE EPIDEMIC, AND FAIL TO PROTECT BABIES FROM BEING BORN WITH HIV. THESE BLACK LEADERS ARE DEAD

SET AGAINST NEEDLE EXCHANGE BECAUSE THEY FEEL THESE PROGRAMS WORK DIRECTLY AGAINST THE EFFORTS OF MANY, INCLUDING THOSE OF YOU HERE TODAY, TO KEEP OUR MEN AND WOMEN FROM SLIDING DEEPER INTO DRUG ADDICTION AND DEEPER INTO DESPAIR, INSTEAD OF GETTING THEM INTO TREATMENT AND OFF OF DRUGS FOR GOOD. THEY SAY IT SENDS A MESSAGE THAT DRUG ADDICTION IS OKAY, AS LONG AS IT'S "CLEAN" DRUG ADDICTION. I SUGGEST A VISIT TO HARLEM HOSPITAL IF THERE IS ANY DOUBT IN YOUR MIND ABOUT THE HORRORS OF DRUG ADDICTION EVEN WITHOUT AIDS. BETTER, THEY BELIEVE, AS DO I, THAT WE MUST EXTEND OUR HANDS MUCH FURTHER IN ORDER TO REACH INTO THOSE COMMUNITIES; PULL OUR YOUNG PEOPLE OUT OF THEIR LIVES OF HOPELESSNESS; AND THEN, THROUGH JOBS AND EDUCATION, GIVE THEM THE TOOLS TO TRULY KEEP HOPE ALIVE

MR. CHAIRMAN, AS A NATION WE HAVE NOT YET DONE OUR JOB ON THE POSITIVE SIDE TO PROVIDE ADEQUATE TREATMENT AND PREVENTION PROGRAMS. AS THE HIV COMMISSION RECOMMENDED, LET US, AS A NATION, COMMIT OURSELVES TO A TEN YEAR SUSTAINED EFFORT TO PROVIDE TREATMENT ON DEMAND FOR DRUG ADDICTS AND EDUCATION FOR

ALL AMERICANS, AS WELL AS STRONGER CRIMINAL SANCTIONS FOR THOSE WHO PROFIT FROM DRUG TRADE. IF SUCH AN ALL-OUT EFFORT FAILS,THEN TEN YEARS FROM NOW WE CAN BEGIN TO TALK ABOUT WHETHER WE WANT THE GOVERNMENT TO SANCTION THE DRUGGING OF SOME OF ITS OWN CITIZENS. LET'S MAKE THE EFFORT FIRST AND NOT CHANCE THE WRITE-OFF OF THE WHOLE GENERATION OF AMERICANS.

IN SHORT, THE MESSAGE THE COMMISSION HEARD WAS NOT DECRIMINALIZE BUT MAKE THE NECESSARY COMMITMENT TO PREVENTION, EDUCATION, TREATMENT AND SUPPLY REDUCTION. IT IS FOR THESE REASONS THAT I STRONGLY OPPOSE EFFORTS TO DECRIMINALIZE ILLEGAL DRUGS. INSTEAD, LET'S MOUNT AN ALL-OUT EFFORT TO TREAT THOSE ADDICTED AND GET THEM OFF DRUGS, WHILE PREVENTING OUR YOUNG PEOPLE FROM EVER STARTING TO ABUSE THEM IN THE FIRST PLACE.

THANK YOU.

U.S. House of Representatives
SELECT COMMITTEE ON
NARCOTICS ABUSE AND CONTROL

Hearing on Proposals to Legalize Drugs

Thursday, September 29, 1988

Written Testimony
of

Tod H. Mikuriya, M.D.

COMPREHENSIVE RATIONAL DRUG ABUSE CONTROL

A PROPOSAL

I. Introduction

Why do people abuse drugs? Because they are unhappy. I have never met a happy substance abuser in my twenty two years of private psychiatric practice. While users may start out as recreational users their use turns to abuse as they attempt to blunt or erase bad or uncomforable feelings with the substance. Trading in a headache for an upset stomach.

It is indeed exciting as a physician to witness the increase in public awareness that tobacco and alcohol are indeed drugs- and the most dangerous ones at that.

Hopefully public policy can properly reflect this perspective in the area of controlling substance abuse.

America and its problem with drugs is like one large family that is dysfunctional but with the capability to be healthy. There is room for openness and respect for dissenting opinions. The criticisms are meant to strengthen moral leadership, which is necessary to effectively decrease drug abuse without abusing people. Unpleasant and inappropriate behaviors must not be kept secret if we are to prevent their reoccurrence.

II. Definition of Drug

Major difficulties arise around the question: "What is a drug?" Millions of dollars and the success or failure of "Smokeless" cigarettes as a product hinge upon the deliberations taking place within the Food & Drug Administration as to whether or not this is a drug.

To a physician "smokeless cigarettes" are drugs but so are regular cigarettes themselves as articulated by the Surgeon General Everett Koop, M.D. The tobacco industry is predictably in high dudgeon over his medically accurate comparison of nicotine to the illicit drugs heroin and cocaine .

The selective denial and euphemizing semantics perpetrated by the non-medical portions of society are a pharmacologic "malice in blunderland" of unreality when subjected to objective criteria of toxicity.

Novel and ever "more dangerous" drugs of abuse are discovered and publicized in the media which disinforms the public by distracting from the "accepted" major sources of danger: alcohol and tobacco.

A. Tool

Substances have no inherent moral properties. They are derived from the uses to which they are put by humans.

Results from substance use depend on expectations, context, personality, as well as the pharmacological characteristics.

1. Medicinal

a. Self-medication

From an early age we are awash in advertising to induce self-medication for a grand collection of ills and undesirable conditions.

Our drug "education" tells us the solutions to our discomfort or difficulty lie outside ourselves- in their nostrums.

The amount of over-the-counter drugs consumed is substantial. With this level of remunerative behavior it is unlikely that a drug-free society is possible.

Products generally percieved as innocuous or in FDAspeak: "Generally Regarded As Safe" are not without toxicity. The most frequent agent in ingestion deaths in children is aspirin products. (Child-proof containers have helped.)

b. Prescription Drugs

The most dangerous and potent substances that must be controlled by the physician, nurse, and hospital under the watchful eye of the state to prevent illicit diversion.

Psychoactive substances are called "controlled" substances with four levels of restriction with IV the least and schedule II the most controlled requiring a triplicate form. Schedule I drugs are unavailabe for prescription.

2. Foodstuff

The California wine industry advertises wine as a a beverage consumed with the meal and not a social lubricant.

The new wine coolers and beer are advertised as social lubricants.

3. Socializing agent

Alcohol and tobacco are not perceived as drugs by the general public and are accorded special privilege of specific exemption from product liability laws and regulation by the Food & Drug Administration.

Alcohol is an intoxicant or inebrient with well known physiologic and behavioral features.

On TV beer and wine coolers are advertised as social "lubricants" or facilitating agents.

B. Forbidden Fruit

The criminalization of substances sets in motion oppositional forces conferring an allure and quality of potency or efficacy that make the users willing to pay five or ten times as much as for legally available items.

Opium, the fragrance, was marketed with these qualities in mind.

Over the counter substances are advertised as the "strongest available without prescription" invoking the image of the equation of potency and efficacy with legal status.

Alcohol, before the age of majority, takes on this quality to the young person eagerly aspiring towards the freedom and empowerment of adulthood.

Similarly, tobacco products are supposed to be withheld before legal adulthood but in reality are freely available in ubiquitous vending machines.

III. Definition of Drug Problems

A. Moral

There are RIGHTDRUGS and there are WRONGDRUGS as defined by law. It is alright to use anything that is not forbidden by law.

In some groups stricter standards prevail that include alcohol and tobacco as WRONGDRUGS.

1. Use constitutes abuse
2. Users are bad or weak
3. Users are ignorant

B. Social

Customs of the family within the community powerfully shape the behavior of its members. Substance use patterns are inextricably entwined with ritual and group values and vary from group to group.

Senator Patrick Moynihan from an Irish background would mistrust a person that didn't drink. This attitude would not be appreciated by the Mormons and the Baptists who are teetotalers. (total abstainers)

Attitudes towards smoking in public are becoming much less permissive with more consideration being given to non-smokers' rights.

Similarly, more attention is being paid to the problem of driving while intoxicated with more accountability being properly expected from the driver.

1. Family
  a. Dysfunctional families
    I. Adult Children of Alcoholics

Adult children of alcoholic families have specific problems not unlike battle trauma; a specific form of posttraumatic stress syndrome. Ugly secrets of abuse and violence that must be kept to protect the alcoholic parent(s) from discovery.

2. Peer group
  a. Dysfunctional or antisocial groups
    I. Gangs

Gangs of angry, alienated young men and women are graced with expensive lifestyle by the money to be made on illicit substances. Their presence in the ghettos have a demoralizing effect on the community.

At the death of major Oakland drug dealer Felix Mitchell there was a lavish funeral and city-wide procession befitting a hero.

3. Community
  a. Poor schools
  b. Inadequate recreational resources
  c. High unemployment

C. Medical

The medical definition of drug abuse is a complex psychobiosocial condition interacting with pharmacology; set, setting, personality, and the drug. The parameters are enumerated in the Diagnostic and Statistical Manual of the American Psychiatric Association DSMIII-R page 169:

A. A maladaptive pattern of psychoactive substance use indicated by at least one of the following:
  1. continued use despite knowledge of having a persistent or recurrent social, occupational, psychological, or physical problem that is caused or exacerbated by the use of the psychoactive substance.
  2. recurrent use in situations in which use is physically hazardous (e.g. driving while intoxicated)

B. Some symptoms of the disturbance have persisted for at least one month, or have occurred repeatedly over a longer period of time.

1. Physical
  a. Predisposing genetic factors
    I. adenylate cyclase defficiency in alcoholism
  b. Illness
  c. Injury
  d. Genetic Injury
2. Psychological
  a. Poor self-esteem
  b. Ignorance
  c. Poor communication skills
  d. Inadequate self-discipline
  e. Poor coping skills

IV. Solutions to Drug Problems

There are two basic strategies with different Goals and expectations. Moral= "drug free"= prohibition at all costs. Medical/social = minimize mortality and morbidity in a cost effective way.

> Unless the conscience of the individual goes freely with the legal restraint, it partakes either in a great or small degree of the degradation of slavery. Scarcely any degree of utility short of absolute necessity will justify a prohibitory regulation unless it can be made to recommend itself to the general conscience; unless persons of ordinary intentions believe already, or can be induced to believe, that the thing prohibited is the thing which they ought not wish to do.
>
> -John Stuart Mill (Political Economy)

Programs and policies should be governed by the principle of least interference with the privacy promoting dignity of the individual while protecting the rights of others.

A. Moral

The enforcement/corrections agencies bear the main responsibility of implementing codified moral strictures: laws.

1. Interdiction
2. Deterrence to sellers, producers
   a. Retribution
      I. Confiscation of property
      II. Incarceration
      III. Parole/probation
   b. Restitution
3. Deterrence to users
   a. Surveillance

As presented in Gulliver's Travels, (1726) by the British satirist, Johnathan Swift, one of the academic pursuits at the mythical Grand Academy at Lagado by professors was to examine the content of excrement to determine the loyalty of subjects. This is remarkably precient of urine drug testing in the 1980's.

I. Urine drug testing

One of the vilest and most vicious abuses of technology when administered without true voluntary contractual agreement.
State rape. Invasion of the bladder police.
A humiliating demonstration of the ascendance of the employer over the individual.

Would the signers of the Declaration of Independence have urinated into the specimen bottle?

Would Congress allow an observed urine specimen to be taken on themselves?

The urine drug test is the act of primacy of the organization over the individual. It is the contemporary chattelization of the individual.

The player does not order the club owner to undergo testing.

b. Sting and other user arrest operations

4. Education
   a. Prevention

Moral education stresses badness of use and the consequences, emphasizing social and legal sanctions. Abstinence is emphasized for all illicit drugs because of illegality. Abstinence may extend to all psychotropic substances.

B. Social
1. Media improvament

The coverage of drug issues by the media has a major role in forming public perception as to the properties of drugs.

Repeated sensationalitic single substance stories decrying the dangers and looking to enforcement for yet more laws and advice on social policy.

Uncritical and naive acceptance of statements of government officials and failure to do basic checking of morgue clippings on the same topic. If New York Times reporter, Peter Kerr,during the September 1986 interview with Dr Richard Hawks of the National Institute on Drug Abuse had read the piece by Janet Brody in 1980 he would have appropriately confronted his assertion that cannabis had increased in potency. Using the old NIDA figures there had actually been a drop.

Investigative journalism in the drug area could use some encouragement away from usual "rip & read" behavior to questioning context from an informed perspective.

2. Education

Education must begin within the family by example and without hypocrisy. This ethical standard must extend to the community.

School programs must be started in kindergarten and extended through the 12th grade and appropriate to the abilities of understanding.

My sister's 7 year old son said "stop mother you mustn't drink and drive" as she opened a soft drink can as she drove away from the super market. When asked about where he had heard about this it was at school in the drug awareness class. He has never seen a drunk or an alcohol abuser although his parents frequently entertain with alcohol products.

Drugs as tools have risks and benefits. Critical thinking and informed independent awareness are objectives. There is no pharmacologic free lunch. What goes up must come down, and vice versa.

Train alternative coping skills to minimize drug abuse. Drugs are used to suppress, minimize feelings as well as manage moods. Affirmative alternatives must be substituted.

a. Drug Advertising Reform

The beer industry depicts alcohol as a socializing agent as compared with wine advertisers that depict alcohol as a foodstuff. (Wine "coolers" appear to be marketed more like beer.)

Repeal of product liability exemptions would introduce an appropriate restraint in the content of advertising which would be preferable to banning advertisment altogether.

Today I received an envelope full of coupons from Carol Wright (c) 1988 Donnelley Marketing to Help Kids Lead a Drug-Free Life (TM) Just say no. Included were coupons for caffeine (coffee) and pseudoephedrine, a decongestant with stimulant properties which is banned in Britain for oral use. Both of these drugs would have you banned from the Olympics, pseudoephedrine altogether and caffeine over certain levels.

I. Equal time for self-regulation messages
All the headache advertisements depict the source of the headache being imposed from without, necessitating an external solution. Self-relaxation techniques in many cases would be more effective, with no side-effects and zero expense.
b. Drug awareness
I. Abstinence desirable
II. Responsible medicinal use
3. Replacement
4. Jobs and dreams
a. Community programs
I. Sports
II. Music and the Arts
III. Educational
IV. Self-regulation training
C. Medical
1. Stepchild of public policy
a. Less popular than moral model
I. Last funded, first cut
b. Inadequate money for treatment
I. Cutbacks of government funding
II. Inadequate health insurance
c. Need ten times as much for voluntary treatment
d. Need mandating of adequate treatment standards
I. Denying or delaying treatment by HMO
II. Cutbacks in medicare and medicaid coverage
III. Nine out of ten calls to clinics must be turned away
IV. Waiting lists for clinics 6 months or more
e. Worsening impact on abuser and family
2. AIDS and Intravenous Drug Abusers
a. Criminalization causes networking
In public health terms the climate of illicitude is an environment favorable to congregation of hosts to spread the disease dependent on the

vector of shared needles and mediated by ignorance.

I. Addict needs to hustle & score

Since illicit drugs are not available through the physician or pharmacy alternative networking is necessary to obtain the drug. The user must form collaborative ventures to locate and buy the drug.

A. Sharing of needles

Upon the successful location and purchase of drug it is the celebration of success and the functional expression of belief that the drugs are as pure and strong as represented.

1. Spread of AIDS

3. Education (preventive medicine)
  a. Stress management training
  b. Diet & exercise counseling
  c. Effects and consequenses of drug use

4. Treatment/Rehabilitation

Voluntary vs involuntary: Ideally voluntary using reason and education. Control, if not exerted by the individual, is imposed from without. During intoxication and withdrawal this is most critical an issue because of mental impairment principally of the affect.

a. Detoxification

Withdrawal from levels of acute and chronic intoxication must be performed with appropriate medication.

I. Overregulation

In the San Francisco bay area at present there are few in-patient detoxification facilities allowed to use methadone detoxification for opiate dependence. In order to qualify for this service it is necessary to go through a complicated procedure with federal and state enforcement authorities that discourages most programs and forces a substandard practice of so-called "symptomatic" detoxification that utilizes sedatives and blood pressure medicines to diminish symptoms. The use of symptom suppression instead of longer acting narcotic drugs with specific cross-tolerance for detoxificaton is less acceptable to the opiate addict which is reflected in a higher rate of premature departures against medical advice from drug treatment programs.

b. Assessment/Evaluation

Unless serious underlying mental illness or brain deficit is recognized, the condition will worsen, further complicating or defeating treatment efforts. It is important that appropriate responsive interventions take place to optimize recovery.

c. Group and Individual Psychotherapy
   Individual psychotherapy or counseling is useful to help the substance abuser deal with specialized problems as well as give information to the staff to help them respond to the abuser's needs.

d. Family Involvement

e. Support Groups
   The recovering individual must avoid former drug-involved peers in order to develop a drug-free lifestyle and must become involved with others supportive of this.
 I. AA, NA, Adult Children of Alcoholics
    Alcoholics Anonomous, Narcotics Anonomous, Marijuana Addicts Anonomous, and Adult Children of Alcoholics all play vital roles in rehabilitation by providing the needed group support necessary for continued abstinence and sobriety of the individuals.

f. Clinics and pharmacy maintenance programs
 I. Voluntary drug users' co-operatives
    A new category of legal non-therapeutic users of controlled substances must be created making available all drugs listed in the contolled substances act of 1970 for actual controlled use.

    Success of the program is based on the assumption that the rate of abuse to use will be low.

  A. Non-profit community board
     A non-profit community board mandated to protect the users from exploitation as well as the public from health and safety risks.
   1. Users, Pharmacists, Public Health, general community
  B. Enter by written test at age of majority
   1. Demonstrate knowledge of drugs' effects
   2. Informed responsibility and consent
   3. Physical and laboratory examination
    a. Voluntary periodic follow-up study
  C. Drugs back in drug stores
   1. Disperse addict populations
    a. "Shooting galleries" and "Rock Houses" obsolete.
   2. Decrease sickness among addicts
    a. Giving out needles is only a half-way measure
     I. AIDS in the IV drug user population better controlled
    b. Develop less toxic drugs
    c. Educate to minimize abuse and eventual quitting
  D. Transaction-fee supported
   1. Provide funds for treatment and rehabilitation
   2. Provide information of drug and quantity
  E. Community Drug Control Agency
   1. Executive staff
    a. Assess information from pharmacies
  F. Abusers referred to treatment or enforcement

1. Priviliges suspended & referred to police
   a. If furnished to a minor
   b. Poisoned or impaired someone else
   c. Driving while intoxicated
2. Referred to detox and treatment program providers
   a. Evaluation
      I. Referral for specialized treatment

G. Continuing research and education

The continuing study at Framingham, Massachussetts provided us with the definitive information concerning the connection between smoking, lung cancer, heart, and other circulatory diseases. In order to restore a source of legitimate and undistorted medical information as to the connections between drugs and their hazards, treatments, and prevention, an ongoing study is required on a large scale.

H. Credit card information handling
1. Quick, cost-effective and proven
   a. Rapid identification and control of abusers
2. Accurate consumption information
   a. Improved public health data source

V. Costs and who pays.

Ideally costs should be borne by the users and the drug industry with any taxes collected earmarked for prevention and treatment of drug abuse.

A. Accountability

The fractured denial-ridden reality for alcohol and tobacco products has, for the most part, been reflected fiscally. Excise and other taxes collected are applied to the general fund. Government inherently is in conflict of interest-encouraging consumption to generate taxes while committed to minimize use of alcohol and tobacco.

1. All taxes to prevention and treatment
   a. Reliable source of funding
2. Remove product liability exemptions

   Alcohol and tobacco products have been granted specific exemption from product liability laws. Removal of this concrete expression of denial of industry responsibility will motivate the promotion of more responsible and safer use of their products.

3. Remove tobacco price supports

   For the sake of consistency of policy toward the discouraging of tobacco use it is inappropriate for taxes to be used for this purpose.

4. Users

Users should bear primary responsibility to pay for their drugs as well as treatment.

a. Transaction fees
b. Fee for service
c. Insurance copayment

VI. Marijuana: legalize for home cultivation and adult personal use.

A. No verifiable problems since legalized in Alaska in 1975

Ravin v. Alaska determined that the constitution of the State of Alaska under its right to privacy Article 1, sec 22 permitted the cultivation and use of marijuana in the home.

Hearings held in the Alaska state legislature April 13 and 14 of this year on a bill to recriminalize marijuana concluded there was no compelling need to change the law.

B. Similar precedent with 250 gallons/year for home wine and beer
C. Numerous commission findings low danger with moderate use.
1. Indian Hemp Drugs Commission Report 1893-1896
a. Recommended not taxing personal use
b. Commercial tax moderate rate
c. No capital involvement in production
2. Panama Military Study 1931
3. New York Mayor's Committee 1939-1944
4. Canadian Government Commission 1972
5. National Commission on Marijuana and Drug Abuse 1972
6. Institute of Medicine 1982

D. Recent claims of higher potency and danger false

In 1986 the late Sidney Cohen, M.D., initiated an oft- repeated claim that marijuana was getting more potent and therefore more dangerous. Review of the literature from as far back as a hundred years ago failed to confirm this. Recent claims as to 1400 % increase in potency are baseless.

E. Commercially produced sold through drug stores
F. Subject to product liability and purity laws

VII. Drug testing fairness

A strict moral integrity and consistency must apply if co-operation is expected in this most invasive procedure.

If a citizen's home is his/her castle should not one's bladder be even more a sanctum sanctorum.

A. No warrantless searches

Consistent with respect for the individual's right to privacy it is appropriate that a warrant be obtained for this most intimate search based on compelling need to know and probable cause.

B. Those ordering tests undergo testing

To ensure a moral integrity of the process and to demonstrate the obligation to uphold laws which are applied equally to all citizens it is appropriate that all in authority ordering drug testing undergo the same tests- on a random basis.

VIII. Responses to the Chairman's questions

A. What narcotic and psychotropic drugs would be legalized?

1. All

B. Who would be allowed to buy these narcotics?

1. Age: determined by the state consistent with alcohol laws.

2. Adults presenting valid drug user status identification.

3. Checked at point of sale

C. Would drugs be sold to people who just want to experiment?

1. Would-be users would have to pass written & physical tests

a. drug effects, user rules and responsibilities

b. passing the test demonstrates informed consent

2. detect and restrict specific medical conditions

a. epilepsy, anemia, liver, alcoholism

I. specialized medical counseling and monitoring

D. Where would drugs be sold, in tax supported ,governmemt

E. drug dispensaries, "rock houses" or "shooting galleries"?

1. Participating pharmacies.

a. Disperse and redefine user population

I. discourage dysfunctional group behavior

The only thing that drug addicts and habitue's have in common is finding and obtaining the drug. Anyone familiar with the non alcohol-nicotine addict subculture knows how boring the constricted world of the junkie is: hustling to score to avoid being sick. Expanding that behavioral cage to the pharmacy along with other drug users would remove the need to congregate to comiserate- and spread disease.

One Historical Precedent

In contemplating the best way to control the sale of hemp drugs in British colonial India in 1896 after an exhaustive study on different regulatory schemes in use throughout the country they concluded that: the government should not become involved in a capital way! no warehouses or shops but to tax at a moderate rate low enough so as not to encourage illict production. Personal and home cultivation of hemp was permitted untaxed.

2. Government crack houses or shooting galleries an anchronism

a. addicts to illicit drugs are antiauthority

As a population the illicit drug users are not the conformists of the nicotine-alcohol dominated culture who are willing to put up with the various socialist make-work state liquor stores as in Pennsylvania and Oregon.

Putting other drugs in the state stores would perhaps send the "wrong signal" that use was encouraged. Use of pharmacies would be preferable since the self-medication basis of use would be emphasized.

b. Legal drugs back in the pharmacies makes them irrelevant
c. government would probably not do a very good job anyway
F. Where would we obtain our supply of these "legal" drugs?
1. Where we currently obtain our supply of our legal drugs
a. World pharmaceutical industry/market
b. Illicit market is an aberrant phenomenon caused by the laws
G. Would private industry be allowed to participate in this market
1. Pharmacies
a. Dispense drugs
2. Pharmaceutical Industry
a. Supply drugs
b. Inform drug control
3. Banking/Credit Industry
a. Support treatment/control
4. Health Industry
a. Treatment, rehabilitation
b. Prevention
5. Insurance Industry
a. Prevention, risk control
b. Treatment, cost control
H. How many people projected to become addicts through "legal drug
1. Unknown but drug-related crime would be significantly lessened
2. The characteristics of the addict population would change

Prior to the passage of the Harrison Act in 1914 the typical addict was older and female. Since that time the profile of the addict has been overwhelmingly the young male. Decriminalization of users would probably even out the difference between the sexes and the average age would increase.

a. Dyssocial/antisocial groups created by the drug laws

Oppositional networking organizations are funded by the high illicit profits from drug trafficking.

I. If drugs legalized would we allow use by safety sensitive jobs?
1. Use of illicit drugs may not impair functioning.
2. The military has used amphetamines to improve performance
3. Athletes' improved performance on illicit drugs is an issue
4. Prescribed or over-the-counter drugs may impair functioning.
a. Sedatives, narcotics, antihistamines, and antihypertensives
5. Non-compliance with prescribed medications may impair function
a. Antiepileptics, major tranquillizers, stimulants, analgesics
6. Drugs are being widely used today without difficulty.
7. Performance and behavior in the situation is the issue.

8. Urine testing results do not reflect current mental state
9. Testing of the individual is a demeaning antisocial behavior

J. If drugs were legalized how to discourage children from using?
1. Though any measures that enhance their dignity.
    a. By example
    b. By education
    c. self discipline
    d. critical thinking
    e. By substituting useful activities
2. Changing laws to remove the allure of forbidden fruit
    a. Adolescents are vulnerable
        I. Oppositional behavior for self-differentiation

The adolescent frequently will engage in behavior that is contrary-wise to the parents in order to establish his/her separate identity from them.

K. Effects of legalizing drugs on the health insurance industry?

A significant benificent effect on the health insurance industry would result from the availability of significant funding needed for the treatment of substance abuse problems. Adequate coverage would be provided for these problems instead of the gross unavailability of this insurance today.

1. Voluntary users co-operatives

Predicated on the premise that the ratio of users to abusers would be significant based upon experience with alcohol, significant funds would be generated to provide for treatment and rehabilitation.

2. Expand product liability laws

If alcohol and tobacco products were not exempted, the revenues available for personal injury settlements would be substantial. The alcohol and tobacco industries would become motivated to co-operate with the insurance industry to minimize risk.

3. Earmark taxes for treatment

The assignment of all taxes collected on alcohol, tobacco, and drugs for treatment, rehabilitation, and prevention of substance abuse constitutes the fiduciary articulation of a principle of accountability and consistency of governance.

The utilization of the governmental compulsion to tax for the provision of a reliable source of funding for treatment and rehabilitation would be a clear improvement over current ambivalent and inconstant policies.

L. Do we know that the addicts wouldn't revert to crime anyway?
1. Much less needed to feed their habits
2. No financial incentive without the illicit markeup.

M. Would the black market dry up?
1. Black market present but much smaller
2. Comparatively less and not violent

a. White collar credit card fraud
  I. Fewer cases
  II. Not on the streets.

N. Would addicts be content with their dose?
  1. Addicts would determine their own maintenance doses
  2. Help would be available if they needed it
    a. detoxify to quit
    b. detoxify to reduce size of habit
    c. switch to another drug

IX. Rational Drug Abuse Control Impossible

A. Corruption

Significant numbers of cases of police succumbing to the temptation of large amounts of money detract from public confidence on which police depend.

Of equal concern is larger scale corruption manifested by secret organized government crime that threatens both both domestic and foreign policy.

1. Loss of faith in leaders

The drugs for guns for the Nicaraguan Contras furnished by the CIA with the help of the Panamanian strongman, Manuel Noriega, do little to help the credibility of the resolve of the war against drugs and just saying "no".

2. Underground government

The use of mind-altering drugs by the OSS and then later the CIA began in 1947 and continued at least through the 1970's.
"Acid Dreams" Martin A. Lee & Bruce Shlain Grove Press 1985 chronicle some of the abuses under this system on witting unwitting subjects.

Federal, state, and academic psychiatric institutions were part of this secret government and worked on "cures" through attempts to brainwash through massive doses of hallucinogens, twice-a-day electroshock, sleep deprivation, stimulus overload and other "therapies".

3. Encourage hypocrisy

As the bootleggers in prohibition paid off the politicians and the police, the temptations of the easy money to be made were great.
The high margins of untaxed profits on the illicit drugs provide a force to favor the criminal market over efforts to eradicate.

B. Unfairness

1. Selective and racist

Blacks are arrested at least five times

as frequently for drug crimes as whites here in California.

2. Classist

When a person is ordered to undergo urine drug testing the order comes from someone in authority having power over the person. The order is never directed upward to an authority.

The poor and undereducated are most likely to run afoul of drug laws.

3. Unconstitutional

Unconstitutionality in the drug issue is seen in the coercive behavior of the state toward the individual- a functional demeaning and removal of personal freedoms. A basic mistrust of the citizen to manage personal freedom.

a. Confiscation of property without trial

I. Presumptive guilt

b. Invasion of the person

What could be more humiliating and demeaning than the forced observing a fellow citizen urinate? Perhaps cavity and strip searches. These activities are state rape.

C. Rule by special interest group

1. Alcohol & tobacco industries: well-fed dogs in the manger

The assessment of the results of the latest cases of attempts to get settlements for lung cancer showed that the tobacco industry lawyers were aggressive, better funded than the plaintiffs, and able to spend large amounts of time and money. The plaintiffs' lawyers will think long and hard before trying it again.

2. Government

a. Enforcement

I. Extend control and influfence

b. Politicians

I. Pander to unreal but showy solutions.

X. Summary Proposal

A. Remove product liability exemptions for alcohol and tobacco.
B. End price supports for tobacco prices.
C. Set up voluntary drug users co-operatives
D. Legalize home cultivation of cannabis
E. Forbid warrantless searches of citizens
F. Test those who order tests for drugs.

XI. Conclusion

I am under no illusion that the changes I have proposed are at all possible in the height of the American social rutting season and collective altered state of consciousness known as presidential election campaign.

As a citizen I am proud to have the privilege of bringing these dissenting notions to a marketplace of free ideas.

Hopefully, reason and decency may eventually prevail as social policy over the current immoral moralism of the "War Against Drugs", which is being lost despite ever more draconian measures, whose results are worse than the drugs themselves.

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Comprehensive Drug Abuse Control Proposal

speaking out

Taming drug-dependency with a credit card

By Tod H. Mikuriya, M.D.

Imagine using a credit card to get heroin or nonprescription amphetamine from the neighborhood druggist. It's part of my proposal for putting both physical or psychological drug addictions under the control of county medical societies instead of street dealers and "feelgood" doctors.

In my proposal, those hooked on narcotics, barbiturates, and other psychoactive drugs could seek help from a local nonprofit group called a Drug Control Agency (DCA). Run jointly by the county medical and pharmaceutical societies and staffed by physicians and other addiction specialists, it screens applicants medically and offers drug seminars that culminate in written exams. Anyone judged a safe bet for participating responsibly in a dispensing program receives a credit card for purchases at designated pharmacies.

There are no prescriptions and no purchase ceilings. But a DCA has predetermined a safe dosage ceiling for each participant, and computers handling the credit transactions would spot possible abuse from drugstore invoices. A DCA, for instance, might refer a true heroin abuser to a methadone maintenance program.

The program won't burden taxpayers. Participants will pay out of pocket for their drugs at prices just high enough to support the DCA and provide modest profit for the druggist. Without criminal drug-suppliers leaching off huge profits, a heroin addict—to use one example—might spend $3 a day instead of an illicit $100. This program couldn't begin en masse without changes in narcotic and controlled-substance laws, but a pilot program could pave the way.

Health and narcotics officials complain that my plan isn't geared to break drug-dependency. But, often, that's neither possible nor desirable. Both the literature and my own experience as a psychiatrist in drug programs suggests that 40% of those dependent on psychoactive drugs are self-medicating for pre-existing psychiatric ailments. There's evidence that heroin is being used for schizophrenia and other psychoses, methaqualone for anxiety, and amphetamines for depression.

There's also evidence that people addicted to such drugs can learn to control their intake so as to lead long and productive lives. So why demand abstinence from self-medicators as well as those who originally sought a drug thrill? It hasn't worked, anyway.

The success of the British drugstore dispensing program for heroin addicts suggests that DCA programs would virtually purge heroin of criminality here. They'd cut off the financial lifeline to illicit suppliers and other parasites who've defied the most strenuous efforts of law enforcers. And addicts who could afford their drugs honestly—even from welfare checks—could abandon shoplifting and more violent crimes.

Methadone maintenance programs, serving about 10% of heroin addicts, are no panacea. They set arbitrary doses instead of letting addicts self-titrate responsibly. And, by gathering addicts together each day, they reinforce abuse and criminality.

This country's "controlled substance" policy is an Orwellian euphemism. It's only succeeded in igniting wildfire in the streets. The realities of drug-dependency call for a well-regulated but nonpunitive dispensing program. It's best for both addict and society.

Dr. Mikuriya, former director of marijuana research for the National Institute of Mental Health and a former consultant to the methadone maintenance program of Alameda County (Calif.), now practices psychiatry privately in Berkeley.

Speaking Out is a forum for the expression of views of interest to physicians. MWN invites contributions, which are subject to editing for clarity and abridgment. Manuscripts of about 650 words accompanied by a self-addressed envelope should be submitted to: Speaking Out, MEDICAL WORLD NEWS, 211 East 43rd Street, Suite 401, New York, N.Y. 10017.

EndPaper

Controlling 'Controlled Substances'

BY TOD H. MIKURIYA, M.D.

Since the passage of the Harrison Narcotics Act in 1914, the problems of drug dependence have been officially and functionally regarded as a moral defect — needing retribution or deterrence — not as an emotional or metabolic disorder requiring medical intervention. Consequently, police, courts and prisons have been utilized in attempts to deter non-medical drug use with their remedies or retribution.

Despite vigorous and continuing efforts at great expense over the years to enforce these laws, there has been a minimal impact on illicit drug trafficking. As noxious side-effects of this criminalization we have the obvious increase in crime, motivated by the high illicit profit margins, complications and more red tape for the health professions and ineffectual, self-serving expensive government agencies that keep reassuring us of their utility and need for continuance.

The term "controlled substances" is an ironic Orwellian political euphemism much like "intelligence" as in CIA, or "security" as in weapons for a foreign country. The illicitly produced and diverted drugs continue to be bought and sold beyond control and should more properly be called uncontrolled substances.

As long as the huge illicit profit margins persist this situation will not only continue, but probably escalate.

SUBSTANCE	RETAIL PRICE	STREET PRICE
Amphetamine	$5-15/100	$25-200/100
Cocaine	$3/gram	$75-125/gm
Methaqualone	$79.50/100	$300-500/100

Street price data from High Times, May 1981. Retail prices from [illegible] Spring 1981 Catalog and [illegible] Hospital Pharmacy [illegible] charge [illegible]

The flexibility of the illegal manufacturing and trafficking operations has demonstrated over the years their ability to largely elude law enforcement to supply a ready market willing to pay the sumptuary markup.

One must however add to this primary cost the surcharge of criminality. Secondary drug crime is unfortunately excessively costly to both the user and society through the crimes against person and property. In the instance of heroin the excessive cost of the drug often causes the addicts to turn to shoplifting, forgery, burglary and robbery in order to support this expensive habit.

Despite the valiant and continuing efforts by enforcement and corrections agencies, the drug use and drug-related crimes continue, diverting and attenuating the resources of public service agencies. The current load on their resources and those of correctional institutions has materially contributed to the crisis in crime. To decrease crime and specifically confront this chronic social ulcer of non-control of non-medical psychoactive drug use, it is appropriate to set up a voluntary, medically supervised dispensation system for psychoactive drugs paid for by the users.

Spoon and syringe (above) seized from a heroin user. (left) [illegible] and an illicit dealer's price list

My proposal is for a voluntary, non-prescription controlled substances dispensing program supported by its consumers and run by the county medical society through participating pharmacies. The program would be responsible for achieving optimum health and safety for both the consumer and the society.

All revenues derived from transactions would be earmarked for support of the program, which would include dispensing, administration, user education, treatment of adverse reactions, user health surveys, research. Users would be eligible to enter the program at the age of majority and would be required to:

1. Undergo screening and medical tests.

2. Demonstrate informed consent by passing written tests on:

   a. Mental and physical effects of specific drugs.
   b. Program rules and procedures.
   c. Personal responsibilities and liability.

3. Sign an agreement to abide by the terms of the program.

To avoid exploitation of users and provide competent guidance, the county medical society, county pharmacy society and consumers would constitute the board of directors for a non-profit organization. This organization would supervise a credit-card type invoicing system to dispense drugs through cooperating pharmacies. This Drug Control Agency (DCA) would respond to cases of misuse (e.g. admission to hospital or emergency room visit for overdose, public intoxication, complaint of spouse, etc.) by referral to public and private community health resources or enforcement/corrections agencies, as warranted by the nature of the infraction.

DCA would also provide user health advisories, and update new user test questions and education materials. DCA would coordinate voluntary periodic health surveys and participate in research.

Entry dose level would be determined from the participant's drug history at the final intake interview by a drug abuse specialist. If [illegible] were available, a drug-specific dose would be given based upon weight or body surface area. This entry dose level would become the standard against which exceptional or unusual drug use activity would be defined.

Drugs would be dispensed from certain designated pharmacies. Program participants would receive an embossed identification card to be presented to the pharmacy to pay for the drugs. The pharmacy would imprint a special multi-part form and send it to the bank as it would do with ordinary VISA or Master Charge transactions. The participating banks would send monthly statements of drugs dispensed to the DCA office, flagging accounts that show a significant increase in number of transactions or size of order.

In response to such unusual activity, the DCA office would first contact the user by mail and request him/her to meet with a designated drug abuse specialist to attempt to resolve the exceptional drug use pattern or drug related problem. If the incident is either unresolvable or of a serious nature, such as driving under the influence or furnishing drugs to anyone else, the case would be turned over to the Department of Motor Vehicles or the district attorney's office.

If the user fails to respond to the mailed notice, the user's identification card number would be put on a list of those suspended. When the card was presented the next time, the pharmacist would either dispense the requested drugs only in exchange for the card, which would then be destroyed, or refuse to dispense the drugs and refer the user to the drug abuse specialist.

Users may be put on probationary status, or temporarily or permanently suspended from the program.

The program would be self-supporting through fees collected from the users' transactions at a rate, agreed upon by the board of directors, that would meet the costs of the program providers at a reasonable price to the consumer. Costs would be contained by utilizing existing community facilities and even proven transaction recordkeeping methods currently used by banks and pharmacies. ■■

Tod H. Mikuriya is a psychiatrist in private practice in Berkeley. In 1967 he was director of marijuana research for the National Institute of Mental Health.

Cannabis 1988

Old Drug, New Dangers

The Potency Question

TOD H. MIKURIYA, M.D.* & MICHAEL R. ALDRICH, PH.D.**

The story of the new, allegedly stronger and more dangerous marijuana was rebirthed in January 1986 by the late Sidney Cohen, M.D., Professor of Psychiatry at UCLA: ". . . material ten or more times potent than the product smoked ten years ago is being used, and the intoxicated state is more intense and lasts longer." In addition, Cohen (1986) asserted that "the amount of THC [tetrahydrocannabinol] in confiscated street samples averaged 4.1 percent THC during 1984. The sinsemilla varieties were about 7 percent with some samples reaching 14 percent. . . . all marijuana research to date has been done on 1 or 2 percent THC material and we may be underestimating present day smoking practices."

The average potency of marijuana samples seized by the Drug Enforcement Administration (DEA) increased from 0.5 percent THC in 1974 to 3.5 percent in 1985-1986, with sinsemilla (seedless marijuana) at 6.5 to 12 percent, announced Dr. Richard Hawks of NIDA later that year (Kerr 1986: 1). "Parents who experimented in their youth are not aware that the potency is much higher," added Donald M. Delzer, Chairman of the National Federation of Parents for Drug Free Youth (Kerr 1986: 18).

"Now perceived as a hard drug, marijuana has increased 1,400 percent in potency since 1970," proclaimed the flyer of a national conference on marijuana (Henry Ohlhoff Outpatient Programs 1986). Drug abuse treatment professionals soon elaborated on the outcry. Tennant (1986) asserted that the drug of the 1970's contained one to three percent THC, while that of the 1980's contained five to 15 percent. Furthermore, the brain registers the difference exponentially, so the difference between one percent and 10 percent THC was not nine percent, but more like 900 percent (Garcia 1986: 3). Smith (1987) stated that Cohen "taught us that marijuana was a lot more dangerous than we originally thought, particularly with the use of more potent preparations by young people." Inaba (1987) added that "this new, stronger marijuana has a more disruptive effect on brain chemistry and body physiology than we had imagined previously," and mentioned heretofore undescribed side effects among athletes: "Baseball players who get beaned a lot admit to smoking marijuana. It impairs their ability to follow the ball."

In a column for drug abuse counselors, Meyers (1987) advised "supportive therapy" for the effects of the "new" marijuana, which were described as "depersonalization, disorientation, derealization, changes in perception, and alterations in body image . . . acute brain syndromes with temporary clouding of mental processes . . . a change of time sense—where minutes seem like hours—slowed thinking, and feared perception of brain damage." Schick Shadel Health Services drug abuse treatment clinics (Unsigned 1987) now advertise that "marijuana has increased THC content from one percent THC in 1975 to six to fourteen percent THC in 1985 due to hybridization techniques. . . . For those who have become addicted to marijuana, whether it was years ago, or recently, treatment is necessary—even more critical today."

Despite the respectability of these authorities, none of these alarming claims are new, and neither is the potency issue. There are several claims intertwined: (1) that the marijuana available today is much stronger than that available previously, particularly since the early 1970's; (2) that the effects of this so-called new marijuana are different from effects known earlier; and (3) that all previous marijuana research has been done with weak material and is therefore irrelevant. Before leaping on the bandwagon, one should examine the validity of these assertions.

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HISTORICAL PERSPECTIVE

Extremely potent marijuana has been described for 150 years by Western scientists and (with the possible exception of the beanball syndrome) so have the effects of the *new marijuana*. There has been a great deal of research on high-potency cannabis in many countries.

In the paper that introduced cannabis to Western medicine, O'Shaughnessy (1839) discussed the widespread social and medical uses of ganja (sinsemilla) in India and noted symptoms of "delirium which the incautious use of the Hemp preparations often occasions, especially among young men first commencing the practice." Cannabis tinctures soon appeared in Europe and America (Robertson 1847; Savory 1843) and Fitz Hugh Ludlow (1857) described florid psychedelic trips after their oral ingestion, including all the symptoms mentioned by Meyers (1987). The Ohio State Medical Society (McMeens 1860) reviewed some 15 years of clinical experience with the drug and acknowledged the intense but physiologically benign mental effects caused by high doses or idiosyncratic sensitivity.

Wood (1869) reported the subjective effects of a tincture made from North American marijuana, experiencing a distortion in time sense, convulsions and memory loss, but no adverse aftereffects. He reported considerable success with it in the treatment of severe neuralgia. However, 15 years later Wood and Smith (1884) commented on the variable potency of cannabis and outlined appropriate treatment for overdoses in medical practice.

Early investigators (McMeens 1860; Bell 1857) attributed this variability to "defective pharmaceutic processes" employed in foreign countries, and recommended that extracts prepared at home would be preferable. However, extreme variations in locally manufactured preparations were soon recognized in the Dispensatory of the United States (Wood & Bache 1868: 379-382). A practical bioassay technique was gradually perfected starting from the systematic observations of Hare (1887), followed by Evans (1894) and Marshall (1898), to compensate for batch-to-batch potency variations.

Pragmatically, the solution to the overdose/potency problem in both the United States (Wood & Bache 1868: 382) and England was to titrate the dose. In London, a patient who signed a letter to the editors of *Lancet*, W.W. (1890) reported a typical case: W.W. had inadvertently been given an overdose of cannabis for treatment of neuralgia by his doctor and had suffered perceptual distortion, agitation, mood swings, and fear of death. Sir J. Russell Reynolds, M.D., F.R.S., physician to Queen Victoria's household, responded with a recommendation based on 30 years of experience with the drug (Reynolds 1890), stating "that Indian hemp, when pure and administered carefully, is one of the most valuable medicines we possess. . . . a minimum dose should be given to begin with, and . . . the dose should be very gradually and cautiously increased."

During the nineteenth century, social and scientific research on marijuana, as well as tinctures, were conducted with much stronger material than is available on the illicit market today. For example, the Indian Hemp Drugs Commission of 1893-1894 investigated the social, religious and medical uses of *bhang* (marijuana), *ganja* (sinsemilla) and *charas* (hashish). The potencies of varieties from different parts of the subcontinent were evaluated by government chemists and botanists (Evans 1894; Hooper 1894), using the "acknowledged superiority" of Bengal *ganja* as the standard. The Commission found that the moderate use of even highly potent marijuana caused no significant physical, mental or moral damage (Kaplan 1969; Mikuriya 1968).

In the 1890's, at the peak of medical interest in the drug, British chemists (Wood, Spivey & Easterfield 1899) isolated an impure active principle, cannabinol, using a "red oil" distilled from Indian cannabis as a starting point, which was considered to be the active ingredient until the 1930's (Work, Bergel & Todd 1939; Cahn 1931). In 1909, Marshall demonstrated that oxidation during storage was the primary cause of the drug's variable potency. With this advance the pharmaceutical industry shifted its attention to the production of standard extracts that could be used to assay medicinal compounds (Colson 1920). Because it had long been known that *ganja* and *charas* produced the most reliable extracts (Wallich 1883; Robertson 1847), in practical terms this meant the European and American producers had to learn how to grow *ganja*.

Sinsemilla cultivation by the Indian technique of culling male plants from the fields before female plants could set seeds—the very process to which recent researchers attribute the potency of the *new marijuana*—was exhaustively described by the British government in India (Kaplan 1969: 59-84; Prain 1893; Kerr 1877). In an effort to promote Bengali *ganja*, the British Raj imposed an export duty on inferior Bombay *ganja* at the turn of the century, and pharmacognosists in Europe and the U.S. began learning sinsemilla cultivation (Mair 1900).

Holmes (1900) discussed the potencies of Calcutta and Bombay *ganja* and recommended that the former be used for pharmaceutical preparations, either by home cultivation of *ganja* according to the Bengal methods he outlined (Holmes 1902a) or by extracting it immediately in Bengal and shipping it in tightly closed containers (Holmes 1902b). Comparing the potency of cannabis from Uganda,

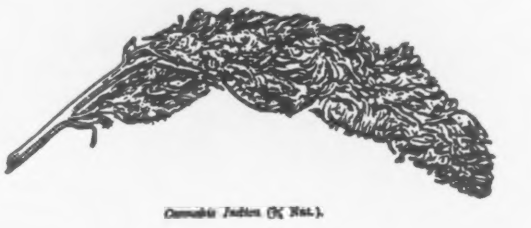

Figure 1. *Cannabis indica* (3/4 Nat.) "Calcutta ganja, which is the very choicest."—Hare, Caspari and Rusby *National Standard Dispensatory* (1909: 374).

France and India, Holmes (1905) urged that only Indian sinsemilla preparations be admitted to the *British Pharmacopoeia*.

Likewise, Whineray (1909) and Hooper (1908) described *ganja* cultivation and manufacture, pointing out that cannabis grown in North America by the Indian methods could be as fully potent as Indian hemp. The *National Standard Dispensatory* of 1909, which included medicines from the pharmacopoeias of the U.S., Britain and Germany, gave the details of sinsemilla cultivation and featured a drawing of a perfect Calcutta *ganja* flower top (see Figure 1) as an example to be emulated by Western cultivators (Hare, Caspari & Rusby 1909: 374).

In the U.S., Hamilton and his colleagues (Hamilton 1918; Hamilton 1915; Hamilton, Lescohier & Perkins 1913; Houghton & Hamilton 1908) demonstrated that if care was exercised in cultivating and processing the plant for extraction, American-grown *ganja* and its extracts were as reliable as those from India and would not deteriorate significantly if stored properly. Information on cultivation of extremely potent seedless marijuana was thus widely disseminated to Western pharmaceutical producers during the first two decades of the twentieth century.

The U.S. government ignored these sensimilla cultivation techniques at the first federal marijuana farm established in 1904 on the Potomac Flats (where the Pentagon now sits) in Washington, D.C. (Silver 1979: 262-263), and as a result the 10-foot marijuana plants grown there and elsewhere in America proved to be much less potent than good samples of Indian hemp (Eckler & Miller 1912). However, private pharmaceutical firms were more successful. The Eli Lilly and Parke-Davis companies ran a cooperative venture at Parkedale (Parke-Davis's farm near Rochester, Michigan) from 1913 until 1938 to develop cannabis extracts for medical use, at first from *Cannabis indica*, but later standardized on a highly potent strain they developed that they called *Cannabis Americana* (Wheeler 1968). Pharmaceutical companies were marketing cannabis extracts that were uniformly effective at 10 mg dose levels (Parke-Davis & Company 1930: 82) 11 years before its official removal from medicinal availability.

In 1941, cannabis was removed from the *United States Pharmacopoeia* (*USP*) at the behest of the Federal Bureau of Narcotics, which suddenly claimed that marijuana had no medical uses (Mikuriya 1973: xx). Yet even the removal of cannabis from the *USP* did not end scientific and social research on highly potent forms of cannabis, ranging from the red-dirt marijuana of the Midwest to the red oil of the laboratories. Adams, Pease and Clark (1940) described improved procedures for preparing purified red oil from Minnesota wild hemp, and comparison of the potencies of Minnesota marijuana and red oil was of significant interest to Loewe, pharmacological director of the LaGuardia Committee (Mayor's Committee on Marihuana 1944: 186ff). Red oil concentrates were used along with marijuana in the LaGuardia Committee's experiments on prisoners, under Loewe's personal direction (Mayor's Committee on Marihuana 1944: 32); for a subjective account see Mezzrow and Wolfe (1946: 317ff). In the 1940's, Adams and Loewe in the U.S. and Todd in England isolated other cannabinoids, including THC, which Adams (1940) postulated as the active principle.

Such isolates were the mainstay of marijuana research during the 1940's and 1950's. A potent marijuana oil created as a truth drug for interrogation purposes by the Office of Strategic Services during World War II (Lee & Shlain 1985: 3-5) was the forerunner of later clandestine experiments conducted by the CIA and the Department of Defense at the Edgewood Arsenal in Maryland from the 1950's to the 1970's (Mikuriya 1973: xxii). Experiments with the designer drug synhexyl, a potent analog of Δ^3-THC, were conducted from the 1940's (Adams et al. 1941)

TABLE I

COMPARATIVE RANGE OF PERCENT THC IN CALIFORNIA CANNABIS SAMPLES, 1973-1974*

Origin	No.	Range of Δ^9-THC (%)	Remarks
Marijuana	76	0.1 - 9.5	Available in California
Mexican	5	1.1 - 3.3	0.2% - 4.3% cannabinol
Acapulco Gold	3	2.7 - 4.2	Distinct cannabichromene
Colombian	11	0.9 - 6.9	0.0% - 6.9% cannabinol
Panama Red	2	4.0 - 5.7	One sample 1971
Thai Sticks	9	2.4 - 9.5	Imported sinsemilla
Big Sur	2	2.7 - 2.9	Domestic sinsemilla
Maui Wowie	3	5.4 - 6.9	Domestic sinsemilla
Unidentified	41	0.1 - 7.8	Many U.S. grown
Hashish	21	0.4 -14.2	Available in California
Lebanese	2	1.9 - 3.7	4.9% -10.6% cannabidiol
Moroccan Kif	2	4.1 - 5.2	2.4% - 2.9% cannabidiol
Afghani Primo	4	1.7 - 5.9	4.2% - 7.8% cannabidiol
Kashmiri	3	6.6 -14.2	2.4% - 4.9% cannabidiol
Pakistani	2	0.4 - 2.3	1.4% - 1.8% cannabidiol
Nepalese	3	3.4 -11.5	One sample 1971
Unidentified	5	0.8 - 5.9	1.1% -14.2% cannabidiol
Hash Oils	42	0.2 -50.0	Available in California
Nepalese	3	3.4 -10.2	
Unidentified	39	0.2 -50.0	

*Samples submitted to PharmChem Laboratories (August 1973-August 1974), with one Panama Red sample and one Nepalese hashish sample (1971). Chromatographs examined by Aldrich (1974).

until the mid-1970's (Lemberger 1976; Pars & Razdan 1976), but were abandoned before its potential was fully explored.

In the 1960's, the identification of pure Δ^9-THC as the active principle in cannabis (Gaoni & Mechoulam 1964) made it possible to assay the relative potencies of cannabinoids directly in human subjects (Isbell et al. 1967). Although Weil, Zinberg and Nelsen (1968) demonstrated the safety of human marijuana research, much of the U.S. research of the 1970's was conducted with low-potency marijuana because the government would not approve human research with high-potency strains. Indeed, in one early study (Jones & Stone 1970), a THC concentrate was removed from Mexican marijuana and then redistributed back into the bulk marijuana to *return* its potency to 0.9 percent THC. Outside the U.S., these strictures did not apply: The fact that cannabidiol interferes with the effects of Δ^9-THC was discovered in Brazil, using both purified cannabinoids on humans (Karniol et al. 1974).

The 1960's and 1970's saw a worldwide flowering of cannabis research, including its social, psychological, chemical, botanical and legal aspects as well as covering an enormous range of potencies and dosages. Major botanical work involved potency questions: observing phenotypes at the University of Mississippi (Fetterman et al. 1971) and in Canada (Small 1979); establishing a lectotype for *Cannabis sativa* L. (Stearn 1974); distinguishing *C. sativa* from *C. indica* and *C. ruderalis* (Schultes et al. 1974); and cultivation techniques for increased THC production (Clarke 1981; Frank & Rosenthal 1978).

Thus the claim by Cohen (1986) that "all marijuana research to date has been done on 1 or 2 percent THC material" is not accurate for the 1970's or for any other decade going back to 1839. It ignores much of the laboratory research in the U.S. that was summarized by Cohen himself (Cohen & Stillman 1976), Hollister (1986) and the National Academy of Sciences (1982), and all of the social research on high-potency marijuana in Jamaica (Rubin & Comitas 1975; Bowman & Pihl 1973), Costa Rica (Carter & Doughty 1976), Greece (Fink et al. 1976) and Africa

(DuToit 1980). It is difficult to think of any country in which the claim is true.

RECENT ESTIMATES OF POTENCY

Since the advent of quantitative analysis technology, there has been sporadic reportage of the percentage of Δ^9-THC and other cannabinoids in natural and semisynthetic cannabis products. Notwithstanding the psychophysical effects of other cannabinoids, the amount of THC present in a marijuana sample is believed to determine the drug's potency (National Commission on Marihuana and Drug Abuse 1972: 50), and potency is usually expressed in percent THC by weight. The results of quantitative analyses performed on street samples of marijuana have been published since the late 1960's. These results are generally higher than the alleged 0.5 percent THC content of marijuana cited for the early 1970's.

Lerner and Zeffert (1968) described the development of quantitative analysis for the determination of THC content, and noted much variation among samples of marijuana, hashish, and red oil (still being used experimentally in the 1960's). The THC content of confiscated Mexican marijuana was 0.8 to 1.4 percent, hashish averaged eight percent and red oil 31 percent in 1968.

Quantitative analyses of street samples of marijuana and hashish conducted by Canadian laboratories in 1971 for the Commission of Inquiry into the Non-Medical Use of Drugs (1972: 28-29) showed a range of 0.02 to 3.46 percent THC (median=0.93%) for marijuana, with hashish ranging from 1.0 to 14.3 percent THC (median=4.82%). Samples seized in police raids were less potent: marijuana was 0.05 to 1.65 percent THC (median=0.21%), while hashish was 0.0 to 8.6 percent THC (median=1.3%). The reported difference between confiscated police seizures and street samples submitted to laboratories for analysis may be due to the voluntary samples being submitted precisely because of their extraordinary potency, or that storage conditions in police evidence lockers are hardly optimal for potency stability.

This has a bearing on the potency question because the low potency cited by both Cohen (1986) and Hawks (see Kerr 1986) referred to samples confiscated by the DEA. It has been known since the early days of its isolation (Wollner et al. 1942) that THC oxidizes to cannabinol rapidly in samples stored at room temperature (24°C). Lerner (1963) reported that the concentration of THC in marijuana decreased at a rate of three to five percent under normal room conditions, and Razdan (1970) reported a rate of 10 percent per month. The influence of temperature, light and age on potency was addressed by Starks (1977: 13-15). The low-baseline percentage of THC reported for the early 1970's may be due to this deterioration in confiscated, stored samples. In any case, the low baseline makes the difference in the THC content of later-reported samples appear much greater than it may have been in actuality, assuming that the marijuana smoked by consumers was fresher than stored police seizures.

For a short while in the early 1970's, PharmChem Laboratories in Palo Alto, California, tested and reported the percent of the THC content in anonymously submitted marijuana samples. For 1973, PharmChem reported an average THC content of 1.62 percent in marijuana, compared with hashish at 4.6 percent and hash oil (a refined extract of hashish) at 13.5 percent (Ratcliffe 1974).

In 1974, the DEA published guidelines that no longer allowed laboratories to provide quantitative results directly to the sample donors. This, in effect, restricted public access to analysis information to whatever government officials wished to reveal. However, nonspecific summaries of THC percentage ranges were allowed to be published (Unsigned 1974).

The results of an independent examination of gas-liquid chromatographs of street samples of marijuana from California that were submitted to PharmChem during 1973 and 1974 are shown in Table I. Seeded varieties ranged in THC from an average of 2.2 percent (Mexican) to 4.9 percent (Panama Red), while sinsemilla averaged 2.8 percent for Big Sur "Holy Weed" to above six percent for Thai Sticks and Hawaiian "Maui Wowie." This would appear to be a much more representative sample of the types of marijuana available in California in 1973-1974 than the half-percent grade cited by Cohen (1986) and Hawks (see Kerr 1986), or the one to three percent grade cited by Tennant (1986).

A retrospective summary of street-drug analysis trends from 1969 through 1975 published by PharmChem (Perry 1977) confirms the fact that quite potent forms of cannabis were available on the illicit U.S. market by 1975: "Early quantitative work showed a range of 1.0-2.5 percent THC for average marijuana. In 1975, the range was 1.0-2.5 percent; samples in the range of 5.0-10.0 percent were not uncommon, and some contained as much as 14.0 percent THC. . . . Hash oil (concentrated from hash, usually amber or red in color) and grass oil (from marijuana, dark green or black in color) . . . vary greatly in potency, some samples [containing] up to 40 percent THC." Abundant information on the comparative potencies of cannabis grown in the U.S. and other countries in the mid-1970's was summarized by Starks (1977: 41-87).

In the spring of another election year, 1980, Cohen and DuPont launched a similar campaign, stating that confiscated marijuana in 1975 contained only 0.4 percent THC, while in 1979 the average was four percent, a tenfold increase (Brody 1980: C1). This data conflicts directly with that published by PharmChem for 1975 street samples

TABLE II
CONCENTRATIONS OF Δ^9-THC IN DIFFERENT VARIATIONS OF MARIJUANA[a]

Type	Percent Δ^9-THC by Weight	Normalized Averages (%)[b]
Nepal[c]	2.81	
Mexico[e]	1.68	1.00
Pakistan[e]	1.30	
Colombia[e]		3.00 - 3.50
India[f]		
Grown above 2,000 meters	0.46	
Grown below 2,000 meters	1.39	
Jamaica (ganja)[i]	2.80 (mean)	
United States[e]	0.35	
Sinsemilla[f]		
Fiber	0.21	
Intermediate	3.58	
Drug	6.28	3.00 - 11.00
Hashish		
United Nations standard[d]	2.22(7.40)[b]	1.90
NIDA[d]		
Cigarette 1	0.84	
Cigarette 2	1.86 (2.8)[g]	
Crude marijuana extract[a]	20.00	
Illicit hashish oil[b]	10.00 - 30.00 (up to 60)[b]	20.00
Research harvests[h]	0.90 - 2.80	

[a]National Academy of Sciences (1982: 16): [b]Jones (1980); [c]Braenden (1972); [d]Turner (1974); [e]Turner (1980); [f]Turner (1981); [g]Turner et al. (1979); [h]Rosenkrantz (1981); [i]Marshman, Popham & Yawney (1976).

(Perry 1977) and that shown in Table I. Perhaps one should be thankful that, according to these estimates, marijuana potency *dropped* from four percent THC in 1979 to 3.5 percent THC in 1986 (Kerr 1986).

The most recent comparison of cannabis potencies was compiled from published sources from 1972 through 1981 by the National Academy of Sciences (1982: 16), and is summarized in Table II. It again demonstrates the great range of products available legally (i.e., NIDA samples) and illegally during that decade, and may in fact underestimate some potencies. For example, the 2.8 percent THC content cited for Jamaican *ganja* (Marshman, Popham & Yawney 1976) is slightly lower than the mean 2.96 percent THC material studied by Rubin and Comitas in 1970 through 1972 (Unsigned 1973), and significantly lower than the four to eight percent THC Jamaican *ganja* cited by the National Commission on Marihuana and Drug Abuse (1972: 50).

The government "research harvests" in Table II (Rosenkrantz 1981) are considerably less potent than the sinsemilla samples that averaged three to 11 percent THC (Turner 1981, 1980). Perhaps this is because cultivators at the government marijuana farm at the University of Mississippi, like their predecessors in 1904, never learned proper sinsemilla cultivation (Turner et al. 1979), while illicit cultivators in California and Hawaii were making it standard for the industry (Frank & Rosenthal 1978: 258-259). If so, this alone could explain the wide discrepancies between the potency of marijuana reported by government sources and that actually being grown in the U.S. during the 1970's and 1980's.

SELF-ADJUSTMENT OF DOSE

An important consideration in regard to the potency issue is autotitration, the adjustment of dose by the individual user to obtain optimal effects and avoid unpleasant ones. As noted above, cautious titration of dose was standard practice when cannabis preparations were used in medicine. Smoking marijuana, customary in present social use of the drug, requires knowledge of when to stop in order to avoid symptoms of overdose. The smoked route gives rapid feedback to the user with regard to levels of effect because the drug goes directly to the brain from the lungs, unimpeded by the gut or the liver.

Researchers for the Mayor's Committee on Marihuana (1944: 13) were among the first to notice that experienced marijuana smokers in the "tea-pads" of Harlem routinely practiced autotitration. The confirmed user, they noted, "appears to be quite conscious of the quantity he requires to reach the effect called 'high.' Once the desired effect is obtained he cannot be persuaded to consume more. He knows when he has had enough . . . and is ever-conscious of preventing himself from becoming 'too high.'" Similarly the Commission of Inquiry into the Non-Medical Use of Drugs (1972: 48) observed that "great variations in potency are usually accommodated by the experienced user through a 'titration' of dose (intake is reduced or stopped when the smoker reaches the preferred level of intoxication)." For U.S. users, the National Commission on Marihuana and Drug Abuse (1972: 166) commented: ". . . whatever the potency of the drug used, individuals tend to smoke only the amount necessary to achieve the desired effect."

SUMMARY AND CONCLUSIONS

Observation of the real world of social marijuana use, where autotitration is the norm, renders the scare tactics of the *new marijuana* proponents not only inaccurate but irrelevant. There is much published evidence about the availability of highly potent varieties of cannabis from the nineteenth century through the present day. The effects attributed to the *new marijuana* are the same ones debated for centuries in many different cultures. The assertion that "all marijuana research to date has been done on 1 or 2 percent THC material" (Cohen 1968) ignores several thousand years of human experience with the drug. The old medical cannabis extracts were stronger than most of the forms now available, though the potency of illicit hash oils by the mid-1970's was approaching the level of medicinal preparations available before their removal from the *USP*.

While it may be true that sinsemilla is more widely available than 10 or 15 years ago, its potency has not changed significantly from the 2.4 to 9.5 percent THC materials available in 1973-1974 (see Table I), or the five to 14 percent sinsemilla of 1975 (Perry 1977). The range of potencies available then (marijuana at 0.1% to 7.8% THC, averaging 2.0% to 5.0% THC by 1975) was approximately the same as that reported now. With such a range, the evidence simply cannot support the argument by Cohen (1986) that marijuana is "ten or more times more potent than the product smoked ten years ago." And to say that marijuana potency has increased 1,400 percent since *any* date in history is patent nonsense.

It is not legitimate to imply that *average* low potencies represent the *full range* of potencies available in reality. Neither is it valid to cite the *low end of the range then* as a baseline to compare with the *high end of the range now*. The claimed baseline for THC content in the early 1970's would appear to be too low, probably because confiscated, stored police samples were utilized; and this low baseline makes the claimed difference in potency appear to be greater than it has been in reality.

In sum, the *new marijuana* is not new and neither is the hyperbole surrounding this issue. The implications of the new disinformation campaign are serious. Many people, particularly the experienced users of the 1960's and their children, will once again shrug off the warnings of drug experts and not heed more reasonable admonishments about more dangerous drugs. This is not only abusive to those who look to science, the medical profession, and government for intelligent leadership, but will sully the reputations of drug educators who wittingly cry wolf, and will inevitably diminish the credibility of drug abuse treatment professionals who pass on such flawed reports.

REFERENCES

Adams, R. 1940. Marihuana. *Science* Vol. 92: 115-119.

Adams, R.; Loewe, S.; Jelinek, C. & Wolff, H. 1941. Tetrahydrocannabinol homologs with marihuana activity. IX. *Journal of the American Chemical Society* Vol. 63: 1971-1973.

Adams, R.; Pease, D.C. & Clark, J.H. 1940. Isolation of cannabinol, cannabidiol and quebrachitol from red oil of Minnesota wild hemp. *Journal of the American Chemical Society* Vol. 62: 2194-2196.

Aldrich, M.R. 1974. Comparative range of Δ^1-THC in California cannabis samples at PharmChem, 1973-74. Unpublished manuscript.

Bell, J. 1857. On the haschisch or Cannabis indica. *Boston Medical and Surgical Journal* Vol. 56(11): 209-216.

Bowman, M. & Pihl, R.O. 1973. Cannabis: Psychological effects of heavy use. A controlled study of intellectual functioning in chronic users of high potency cannabis. *Psychopharmacologia* Vol. 29(2): 159-170.

Braenden, O.J. 1972. United Nations reference samples of cannabis. In:

Paton, W.D.M. & Crown, J. (Eds.). *Cannabis and Its Derivatives*. New York: Oxford University Press.

Brody, J.E. 1980. The evidence builds against marijuana. *New York Times* May 21.

Cahn, R.S. 1931. Cannabis indica resin. Part II. *Journal of the Chemical Society* (1931): 630-638.

Carter, W.E. & Doughty, P.C. 1976. Social and cultural aspects of cannabis use in Costa Rica. *Annals of the New York Academy of Sciences* Vol. 282: 2-16.

Clarke, R.C. 1981. *Marijuana Botany*. Berkeley, California: And/Or Press.

Cohen, S. 1986. Marijuana research: Selected recent findings. *Drug Abuse and Alcoholism Newsletter* Vol. 15(1): 1-3.

Cohen, S. & Stillman, R.C. (Eds.). 1976. *The Therapeutic Potential of Marihuana*. New York: Plenum.

Colson, H.C. 1920. Cannabis. *Journal of the American Pharmaceutical Association* Vol. 9: 302.

Commission of Inquiry into the Non-Medical Use of Drugs. 1972. *Cannabis: A Report of the Commission of Inquiry into the Non-Medical Use of Drugs*. Ottawa: Information Canada.

Dominguez, R. 1987. Marijuana trends and trafficking update: Whatever happened to marijuana? *Street Pharmacologist* Vol. 11(2): 1.

DuToit, B.M. 1980. *Cannabis in Africa, a Survey of Its Distribution in Africa, and a Study of Cannabis Use and Users in Multi-ethnic South Africa*. Rotterdam: A.A. Balkema.

Eckler, C.R. & Miller, F.A. 1912. A study of American grown cannabis in comparison with samples from various other sources. *American Journal of Pharmacy* Vol. 84: 488-495.

Evans, J.F. 1894. Report by Surgeon-Captain J.F. Evans, Chemical Examiner to the Governor of Bengal, regarding physiological investigations concerning hemp drugs. In: *Report of the Indian Hemp Drugs Commission*. Appendix Vol. 3: 206-227. Simla, India: Government Central Printing Office.

Fetterman, P.S.; Keith, E.S.; Waller, C.W.; Guerrero, O.; Doorenbos, N.J. & Quimby, M.W. 1971. Mississippi-grown *Cannabis sativa* L.: Preliminary observations on chemical definition of phenotype and variation in tetrahydrocannabinol content versus age, sex, and plant part. *Journal of Pharmaceutical Sciences* Vol. 60(8): 1246-1249.

Fink, M.; Volavka, J.; Panayiotopoulos, C. & Stefanis, C. 1976. Quantitative EEG studies of marihuana, Δ^9-tetrahydrocannabinol, and hashish in man. In: Braude, M. & Szara, S. (Eds.). *Pharmacology of Marihuana*. New York: Raven Press.

Frank, M. & Rosenthal, E. 1978. *Marijuana Growers' Guide*. Berkeley, California: And/Or Press.

Gaoni, Y. & Mechoulam, R. 1964. Isolation, structure, and partial synthesis of an active constituent of hashish. *Journal of the American Chemical Society* Vol. 86: 1646-1647.

Garcia, D. 1986. Stronger pot creating addicts, doctor says. *San Francisco Chronicle* October 4.

Hamilton, H.C. 1918. The stability of Cannabis sativa and its extracts. *Journal of the American Pharmaceutical Association* Vol. 7: 333-336.

Hamilton, H.C. 1915. Cannabis sativa. Is the medicinal value found only in the Indian grown drug? *Journal of the American Pharmaceutical Association* Vol. 4: 448-451.

Hamilton, H.C.; Lescohier, A.W. & Perkins, R.A. 1913. The physiological activity of Cannabis sativa. Comparison of extracts from Indian and American-grown drug upon human subjects. *Journal of the American Pharmaceutical Association* Vol. 2: 22-30.

Hare, H.A. 1887. Clinical and physiological notes on the action of Cannabis indica. *Therapeutic Gazette* Vol. 11: 225-228.

Hare, H.A.; Caspari, C., Jr. & Rusby, H.H. 1909. Cannabis indica. *The National Standard Dispensatory*. Philadelphia: Lea & Febiger.

Henry Ohlhoff Outpatient Programs. 1986. Promotional flyer for "Marijuana Dependence: A National Conference." San Francisco, October 3-4.

Hollister, L.E. 1986. Health aspects of cannabis. *Pharmacological Reviews* Vol. 38(1): 1-20.

Holmes, E.M. 1905. Notes on Cannabis indica. *Pharmaceutical Journal* Vol. 74: 550-551.

Holmes, E.M. 1902a. Cannabis indica. *Pharmaceutical Journal* Vol. 69: 129-131.

Holmes, E.M. 1902b. Notes on Cannabis indica. *Pharmaceutical Journal* Vol. 68: 342.

Holmes, E.M. 1900. Cannabis indica. *Pharmaceutical Journal* Vol. 64: 522-523.

Hooper, D. 1908. Charas of Indian hemp. *Pharmaceutical Journal* Vol. 81: 347-349.

Hooper, D. 1894. Report by Mr. David Hooper, Government Quinologist, Madras, on the results of analysis of hemp drugs. In: *Report of the Indian Hemp Drugs Commission*. Appendix Vol. 3: 197-199. Simla, India: Government Central Printing Office.

Houghton, E.M. & Hamilton, H.C. 1908. A pharmacological study of Cannabis Americana (Cannabis sativa). *American Journal of Pharmacy* Vol. 80: 16-20.

Inaba, D. 1987. Marijuana '87—a new drug. *Recovering* Vol. 1(1): 16.

Isbell, H.; Gorodetzky, C.W.; Jasinski, D.; Claussen, U.; Spulak, F. von & Korte, F. 1967. Effects of (−)Δ^9-trans-tetrahydrocannabinol in man. *Psychopharmacologia* Vol. 11: 184-188.

Jones, R.T. 1980. Human effects: An overview. In: Petersen, R.C. (Ed.). *Marijuana Research Findings: 1980*. NIDA Research Monograph 31. Rockville, Maryland: NIDA.

Jones, R.T. & Stone, G.C. 1970. Psychological studies of marijuana and alcohol in man. *Psychopharmacologia* Vol. 18: 108-117.

Kaplan, J. 1969. *Marijuana: Report of the Indian Hemp Drugs Commission 1893-1894*. Silver Spring, Maryland: Thomas Jefferson.

Karniol, I.G.; Shirakawa, I.; Kasinski, N.; Pfeferman, A. & Carlini, E.A. 1974. Cannabidiol interferes with the effects of Δ^9-tetrahydrocannabinol in man. *European Journal of Pharmacology* Vol. 28: 172-177.

Kerr, H.C. 1877. Report of the cultivation of, and trade in, ganja in Bengal, by Mr. Hem Chunder Kerr, Deputy Collector, on special duty. In: *Papers Relating to the Consumption of Ganja and Other Drugs in India*. Simla, India: Government Central Printing Office.

Kerr, P. 1986. Increases in potency of marijuana prompt new warnings for youths. *New York Times* September 25.

Lee, M.A. & Shlain, B. 1985. *Acid Dreams: The CIA, LSD and the Sixties Rebellion*. New York: Grove Press.

Lemberger, L. 1976. Clinical pharmacology of natural and synthetic cannabinoids. In: Cohen, S. & Stillman, R.C. (Eds.). *The Therapeutic Potential of Marihuana*. New York: Plenum.

Lerner, M. 1963. Marihuana: Tetrahydrocannabinol and related compounds. *Science* Vol. 140: 175-176.

Lerner, M. & Zeffert, J.T. 1968. Determination of tetrahydrocannabinol isomers in marijuana and hashish. *Bulletin on Narcotics* Vol. 20(2): 53-54.

Ludlow, F.H. 1857. *The Hasheesh Eater: Being Passages from the Life of a Pythagorean*. New York: Harper & Row. (Ludlow Library edition, 1974. San Francisco: Level Press.)

Mair, W. 1900. The cultivation and manufacture of the official Cannabis indica. *Pharmaceutical Journal* Vol. 65: 732-733.

Marshall, C.R. 1909. Experiments on the cause of the loss of activity of Indian hemp. *Pharmaceutical Journal* Vol. 82: 418.

Marshall, C.R. 1898. A contribution to the pharmacology of Cannabis indica. *Journal of the American Medical Association* Vol. 31: 882-891.

Marshman, J.A.; Popham, R.E. & Yawney, C.D. 1976. A note on the cannabinoid content of Jamaican ganja. *Bulletin on Narcotics* Vol. 26: 63-68.

Mayor's Committee on Marihuana. 1944. *The Marihuana Problem in the City of New York*. Lancaster, Pennsylvania: Jacques Cattell.

McMeens, R.R. 1860. Report of the Ohio State Medical Committee on Cannabis indica. *Transactions of the Fifteenth Annual Meeting of the Ohio State Medical Society* June 12-14: 75-100.

Meyers, M.J. 1987. More about the "new" marijuana. *Professional Counselor* Vol. 1(6): 3.

Mezzrow, M. & Wolfe, B. 1946. *Really the Blues*. New York: Random House.

Mikuriya, T.H. (Ed.). 1973. *Marijuana. Medical Papers 1839-1972*. Oakland, California: Medi-Comp.

Mikuriya, T.H. 1968. Physical, mental and moral effects of marijuana: The Indian Hemp Drugs Commission report. *International Journal of the Addictions* Vol. 3(2): 253-270.

National Academy of Sciences. 1982. *Marijuana and Health: Report of a Study by a Committee of the Institute of Medicine. Division of Health Sciences Policy*. Washington, D.C.: National Academy Press.

National Commission on Marihuana and Drug Abuse. 1972. *Marihuana: A Signal of Misunderstanding*. Washington, D.C.: U.S. GPO.

O'Shaughnessy, W.B. 1839. On the preparations of Indian hemp, or gunjah. *Transactions of the Medical and Physical Society of Bengal*. 1838-1840: 421-461.

Parke-Davis and Company. 1930. *Physicians' Catalog of Pharmaceutical and Biological Products*. In: Mikuriya (1973: 66).

Pars, H.G. & Razdan, R.K. 1976. Heterocyclic analogs of the cannabinoids. In: Cohen, S. & Stillman, R.C. (Eds.). *The Therapeutic Potential of Marihuana*. New York: Plenum.

Perry, D.C. 1977. Street drug analysis and drug use trends 1969-1975. Part II. *PharmChem Newsletter* Vol. 6(4): 1-3.

Prain, D. 1893. *Report on the Cultivation and Use of Ganja*. Calcutta, India: Bengal Secretariat Press.

Ratcliffe, B. 1974. Summary of street drug results—1973. *PharmChem Newsletter* Vol. 3(3): 1-3.

Razdan, R.K. 1970. In: *Proceedings of the National Academy of Sciences Committee on Problems of Drug Dependence*. 32nd meeting. Toronto, February 17-20.

Reynolds, J.R. 1890. Therapeutic uses and toxic effects of Cannabis indica. *Lancet* Vol. 1: 637-638.

Robertson, A. 1847. On extract of Indian hemp. *Pharmaceutical Journal* Vol. 6: 70-72.

Rosenkrantz, H. 1981. In: *Report of an Addiction Research Foundation/World Health Organization (ARF/WHO) Scientific Meeting on Adverse Health or Behavioral Consequences of Marijuana Use*. Toronto: ARF/WHO.

Rubin, V. & Comitas, L. 1975. *Ganja in Jamaica: A Medical Anthropological Study of Chronic Marihuana Use*. The Hague: Mouton.

Savory. 1843. Extractum Cannabis indicae. *Pharmaceutical Journal* Vol. 3: 80.

Schultes, R.E.; Klein, W.M.; Plowman, T. & Lockwood, T.E. 1974. Cannabis: An example of taxonomic neglect. *Botanical Museum Leaflets, Harvard University* Vol. 23(9): 337-367.

Silver, G. (Ed.). 1979. *The Dope Chronicles 1850-1950*. San Francisco: Harper & Row.

Small, E. 1979. *The Species Problem in Cannabis. Science and Semantics. Volume 1: Science*. Toronto: Corpus.

Smith, D.E. 1987. In memoriam (Sidney Cohen, M.D.). *Journal of Psychoactive Drugs* Vol. 19(2): ii.

Starks, M. 1977. *Marijuana Botany*. Berkeley, California: And/Or Press.

Stearn, W.T. 1974. Typification of *Cannabis sativa* L. *Botanical Museum Leaflets, Harvard University* Vol. 23(9): 325-336.

Tennant, F.S., Jr. 1986. The clinical syndrome of marijuana dependence. *Psychiatric Annals* Vol. 16(4): 225-234.

Turner, C.E. 1981. Personal communication to National Academy of Sciences.

Turner, C.E. 1980. Chemistry and metabolism. In: Petersen, R.C. (Ed.). *Marihuana Research Findings: 1980*. NIDA Research Monograph 31. Rockville, Maryland: NIDA.

Turner, C.E. 1974. Active substances in marijuana. *Archivos de Investigacion Medica* Vol. 5(Suppl.): 135-140.

Turner, C.E.; Cheng, P.C.; Lewis, G.S.; Russell, M.H & Sharma, G.K. 1979. Constituents of Cannabis sativa. XV. Botanical and chemical profile of Indian variants. *Planta Medica* Vol. 37: 217-225.

Unsigned. 1987. *Marijuana Questions and Answers*. Los Angeles: Schick Shadel Health Services.

Unsigned. 1974. Effectiveness of drug analysis curbed. *PharmChem Newsletter* Vol. 3(4): 1.

Unsigned. 1973. Study of chronic use of marijuana demonstrates no chromosome breaks, brain damage, or untoward effects. *Medical Tribune* Vol. 14(39): 1.

Wallich, G.C. 1883. Cannabis indica. *British Medical Journal* Vol. 1: 1224.

Weil, A.T.; Zinberg, N.E. & Nelsen, J.M. 1968. Clinical and psychological effects of marihuana in man. *Science* Vol. 162: 1234-1242.

Wheeler, L.M. 1968. Personal communication. In: Mikuriya 1973: 67-68.

Whineray, E. 1909. A pharmaceutical study of Cannabis sativa. *The Equinox* Vol. 1(1). Reprinted in Regardie, I. (Ed.). 1968. *Roll Away the Stone*. St. Paul: Llewellyn.

Wollner, H.J.; Matchett, J.R.; Levine, J. & Loewe, S. 1942. Isolation of a physiologically active tetrahydrocannabinol from Cannabis sativa resin. *Journal of the American Chemical Society* Vol. 64: 26-29.

Wood, G.B. & Bache, F. 1868. Extractum Cannabis. *Dispensatory of the United States of America*. 12th ed. Philadelphia: J.B. Lippincott.

Wood, H.C. 1869. On the medical activity of the hemp plant, as grown in North America. *Proceedings of the American Philosophical Society* Vol. 11: 226-232.

Wood, H.C. & Smith, R.M. 1884. Poisoning by Cannabis indica. *Therapeutic Gazette* Vol. 5: 514-515.

Wood, T.B.; Spivey, W.T.N. & Easterfield, T.H. 1899. Cannabinol. Part I. *Journal of the Chemical Society* Vol. 75: 20-36.

Work, T.S.; Bergel, F. & Todd, A.R. 1939. The active principles of Cannabis indica resin. I. *Biochemical Journal* Vol. 33: 123-127.

W.W. 1890. Toxic effects of Cannabis indica. *Lancet* Vol. 1: March 15. In: Mikuriya (1973: 144).

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Biographic Data

Tod H. Mikuriya, M.D. is a psychiatrist in private practice in Oakland and Berkeley since 1968. A member of the American Society for The Treatment of Alcoholism and Other Drug Dependence,California Society for the Treatment of Alcoholism and Other Drug Dependence, he has worked on problems of drug abuse since 1967.

He graduated from Reed College and Temple Medical School.

After completing his psychiatric training at Oregon State Hospital and Mendocino State Hospital he briefly directed the New Jersey Neuropsychiatric Institute Drug Addiction Treatment Center near Princeton and was the first director of federal "overground" marijuana research for the National Institute of Mental Health, Center for Narcotics and Drug Abuse Studies.

Dr. Mikuriya has been a consultant to the Alameda County Health Department Alcoholism and Drug Abuse program and introduced the first methadone maintenance program and was an initial planner for the setting up of Project Eden in southern Alameda County.

He is an attending psychiatrist at the Everett A. Gladman Memorial Hospital, Oakland, consulting psychiatrist Fairmont Hospital, San Leandro and staff psychiatrist Merrithew Hospital, Martinez, California.

Dr. Mikuriya is an examining panel psychiatrist for the Cities of Oakland and Berkeley and an examiner for the First Western Medical Group in Oakland.

He was a consultant to the federal Shaeffer Commission in 1972 and the California State Senate Select Committee on the Control of Marijuana in 1974.

Dr. Mikuriya is also a member of the California Medical Association, Alameda Contra Costa Medical Association, American Psychiatric Association, Northern California Psychiatric Society, East Bay Psychiatric Association, Association for Applied Psychophysiology and Biofeedback, and the Biofeedback Society of California.

9-22-88

House Select Committee On Narcotics Abuse And Control

Hearing On Legalization Of Illicit Drugs:

September 29, 1988

Written Testimony Submitted on Behalf of

Julio A. Martinez, Director
New York State
Division of Substance Abuse Services

My name is John Gustafson. I am Deputy Director of the New York State Division of Substance Abuse Services and I am here today representing our Director, Mr. Julio Martinez. I want to thank Chairman Rangel and members of the Select Committee on Narcotics Abuse and Control for inviting me to testify, and for your continued interest in the substance abuse problem in New York.

In recent months, some prominent individuals have called for the legalization of drugs. In general, I believe the proponents of legalization are well-meaning but naive. Calls for legalization appear to be the product of frustration with the difficulties of combatting the complex problem of drug use in our society. After decades of work in the field, I must admit that at times, I also feel frustrated over the enormous scope of the drug problem. I cannot, however, support the legalization of drugs.

Although some proponents have admitted legalization is likely to increase drug use, others have skirted the issue, or said it is impossible to predict what would happen if drugs were legalized. I believe our experience with Crack, during the past several years, is the best preview of what the outlook for all of drug use would be under legalization. Crack is a Madison Avenue executive's dream of the perfect product. It is highly addictive, easy to use, and relatively inexpensive.

The impact of Crack- and cocaine-use in New York has been devastating. Emergency room episodes involving cocaine have increased more than 50 percent in one year. Admissions to New York City treatment programs with cocaine as the primary drug of abuse more than doubled in the past two years. Crack continues to drive most of these increases. For instance, 65 percent of treatment admissions for cocaine abuse report "smoking" as the primary route of administration.

Over the past several years, the use of cocaine by women during pregnancy has been an increasing problem. Between 1985 and 1986, births to women using cocaine in pregnancy increased by 117 percent. During the 1978-84 period, the infant mortality rate for infants whose mothers were substance abusers was about three times higher than the Citywide rate. Recent information indicates the infant mortality rate may be increasing in New York City, after more than a decade of decline, due to births to mothers who are abusing cocaine or who have AIDS.

A baby who tests positive for drugs cannot legally be released to the mother until she enters treatment for her addiction and has made sufficient progress to care for her child. Therefore, babies frequently remain in hospitals long after they medically need to stay. Eventually, most of these babies end up in foster care.

Crack and cocaine have had an enormous impact on the health care system. Crack-addicted babies need intensive care and often become boarder babies. Crack addicts overcrowd emergency rooms, take up psychiatric beds, and require staff to care for them. Crack can bring on pneumonia, chronic bronchitis, searing of lung tissue, heart attacks, and a reduction in the capacity to diffuse carbon monoxide. Chronic use of cocaine may lead to liver and respiratory problems. Nasal septal perforation, which requires surgical repair, is a common outcome of snorting cocaine. The chronic use of cocaine has also been clinically linked to a number of mental disturbances, varying from mild central nervous stimulation to severe depression and psychosis. Acute psychosis can manifest itself in hallucinations, paranoia, and debilitating anxiety reactions that require extended hospitalization.

Laboratory experiments show that, given unlimited access to cocaine, animals will continue taking ever greater amounts until they die. While cocaine is available in every community of New York, it is likely that the expense and danger of buying illegal cocaine have limited its use. Legalizing cocaine and other harmful drugs would lead to heavier and more extensive use. We would see an increase in admissions to emergency rooms, psychiatric hospitals, and drug treatment centers. We would also witness increases in spouse abuse, child abuse and neglect, addicted babies, overdoses, and auto accidents and fatalities.

The terrible social and health consequences of legalizing drugs argue strongly against adopting such a policy. If these negative consequences were restricted to adults, advocates for legalization might have a stronger case. Unfortunately, substance abuse has a devastating impact on children.

Children raised in homes where parents are abusing substances are more likely to abuse substances. These children are at high risk of child abuse and neglect. Children of substance abusers, whether reared in the home or in temporary foster care placements, are more likely to have deficits in cognitive skills, and have difficulties in school performance. Behavior problems such as difficulties in forming relationships, delinquency, and substance abuse are other problems found among children of substance abusers.

The Division's Bureau of Research estimates there are 467,000 children of substance abusers, aged 17 and under, in New York State. This represents approximately one out of 10 children in the State. It is estimated that there were 24,000 births to substance-abusing women in New York in 1986. This represents approximately one out of 10 births in the State.

As I have discussed, parental substance abuse has numerous negative consequences for children. With legalization and the increased levels of substance abuse that would inevitably result, these problems will worsen. Some proponents of legalization have suggested the money saved by no longer enforcing drug laws could be used to support prevention and education efforts. Frankly, I am skeptical. There are so many demands on federal, State, and local treasuries, it is not difficult to imagine such monies being diverted elsewhere. I remember vividly that during the Vietnam War, there was a great deal of talk about a "peace dividend." The theory was that once we were no longer fighting the war, additional funds would be available for domestic spending. After Vietnam, military spending did not decline and the "peace dividend" failed to materialize.

We cannot avoid the unpleasant truth that by legalizing drugs, society would be condoning their use. Legalization would send a powerful message to our young people that there is nothing wrong with using drugs. Under such circumstances, our prevention and education efforts would be much more difficult even if increased funds were made available.

The experience of prohibition is often cited by advocates of legalization. Undoubtedly, prohibition was a law enforcement failure and I certainly do not advocate its return. Those who focus entirely on the law enforcement aspect of prohibition ignore some of the other lessons of that experience. In a May 26, 1988 editorial, The New York Times took issue with those who cite the lesson of prohibition as an argument for legalizing drugs. According to the editorial: "While it failed as social policy, it was a health triumph. Alcohol-related mental and physical illness declined dramatically during the 1920's and then soared after repeal in 1933." Furthermore, prohibition failed because it tried to make alcohol illegal after centuries of legal use in our culture. Once a drug has been ingrained in a society, it is impossible to prohibit its use. Drugs like alcohol were let out of Pandora's Box centuries ago. Unfortunately, there seems to be no putting them back. The lesson this teaches me is that if we ever legalize other dangerous drugs, we must be willing to accept their presence and widespread abuse forever. I, for one, am not willing to accept that.

The experience with two legal drugs, alcohol, and tobacco argues strongly against legalizing additional drugs. Approximately 320,000 deaths per year are attributed to tobacco smoking and 200,000 to alcohol abuse. A study by the Research Triangle Institute estimated the costs to society of alcohol and drug abuse. For 1983, it estimated that the total cost to society of alcohol abuse as $116.7 billion and drug abuse as $59.8 billion. Large as these estimates appear, it seems likely they are conservative. For instance, the Research Triangle study estimated zero as the cost of motor vehicle crashes involving drug abuse. In 1985, a California study of 440 male drivers who were killed in motor vehicle crashes, reported that cocaine was found in 11 percent of the drivers. Further research in California resulted in estimates that 20 percent of the impaired driver arrestees are under the influence of drugs or alcohol-drug combinations.

Especially noteworthy is the Research Triangle Institute's estimate of the costs to society of reduced productivity and lost employment due to alcohol and drug abuse. The estimated cost of reduced productivity due to alcohol abuse was $65.6 billion, and lost employment was $5.3 billion. The comparable figures for drug abuse were $33.3 billion and $405 million. According to the Research Triangle Institute, alcohol, a legal drug, is twice as costly to society as far as reduced productivity and lost employment.
If illicit drugs were legalized, such social costs are likely to rise dramatically. In an era when the United States finds itself in a highly competitive global economy, can we risk the consequences increased drug use would have on our workforce?

Advocates also argue that legalization would allow us to control drugs through regulation. Is this realistic? Handguns are legal and regulated. Yet murder and armed robbery haven't gone away. Alcohol is legal and regulated. Yet alcoholism is widespread. Through Off Track Betting and the lottery, gambling is legal and regulated. Yet there are still bookies and numbers runners. What makes us think that drug use would be any different?

I believe the human and economic costs of legalizing drugs far outweigh any potential benefits. In recent years, a renewed consensus has developed among liberals and conservatives regarding the importance of the family as the backbone of our society. In New York State, we are especially proud that Governor Cuomo has made children and families a priority area for government. I can think of few other actions by government that could contribute more to the disintegration of families than legalizing drugs.

I want to emphasize that I strongly oppose the legalization of drugs. I agree with Child Psychiatrist Robert Coles who said legalization would be a "moral surrender of far-reaching implications about the way we treat each other."

Although I oppose legalizing, I am also opposed to proposals such as instituting the death penalty for pushers and denying benefits to those convicted of drug offenses. The strength of our rehabilitation system lies in a holistic approach to treatment. We have long recognized the importance of providing a recovering substance abuser with education, training, health care, and housing as part of the process of reintegrating these individuals into society. Denying these basic benefits to an individual who is making a sincere effort to become productive is actually counterproductive and may contradict our efforts to encourage substance abusers to come forward and seek treatment.

I believe the best solutions to the drug problem are: 1) increasing the availability of substance abuse prevention and treatment programs, 2) insuring treatment for criminals whose crime is due to their addiction, and 3) a comprehensive commitment from the federal government to address the international problems of drug cultivation and importation.

PREPARED STATEMENT

OF

STEVEN WISOTSKY

Professor of Law
Nova University Law Center

Before the

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

HOUSE OF REPRESENTATIVES

Concerning

A NEW BEGINNING IN U.S. DRUG POLICY

September 29, 1988

> [T]he history of the narcotics legislation in the county "reveals the determination of congress to turn the screw of the criminal machinery -- detection, prosecution and punishment -- tighter and tighter."
>
> The U.S. Supreme Court in
> Albernaz v. United States,
> 450 U.S. 333, 343 (1981)

> The chief cause of problems is solutions.
>
> -- Eric Sevareid

Mr. Chairman, I would like to express my appreciation to the Committee for inviting me to participate in this important hearing on U.S. Drug Policy. This hearing could be and should be the start of a new beginning in the conception and execution of our drug laws. Indeed, if there is one overriding theme in my prepared statement, it is just that: more than anything else -- more than revised laws or the commitment of new resources -- we need a careful, comprehensive study of the costs and benefits of present drug policy, followed by a clear articulation of the fundamental goals sought to be achieved by our drug policy.

First, let me identify myself for the record. I am both a lawyer and a law professor. I have been a full time member of the law faculty of the Nova University Law Center since 1975. One of my primary areas of specialization is the criminal justice system. Since the late 1970's, I have followed developments in U.S. drug law. With the aid of a grant from the Nova Law Center in 1982, I published what is to my knowledge the first critique of the U.S. War on Drugs, the substance of which is clearly indicated by its title, "Exposing the War on Cocaine: The Futility and Destructiveness of Prohibition," 1983 Wisconsin Law Review 1305. More recent publications are set forth in the margin.[1]

My published work in this field has been cited widely by the press, being summarized, for example, in the Atlantic Monthly cover story on cocaine of January, 1986. I am most widely known as the author of *Breaking the Impasse in the War on Drugs*, published by Greenwood Press in November, 1986, and reviewed in the New York Times Book Review Section in December, 1986. I have spoken on drug law and policy at many panels and conferences in the United States and in Europe.

My prepared statement for this hearing addresses three fundamental questions. What is the state of the War on Drugs? How did we get there? Where should we go from here?

The current War on Drugs began on October 2, 1982 with a radio address by President Reagan to the Nation: "The mood towards drugs is changing in this country and the momentum is with us. We are making no excuses for drugs -- hard, soft, or otherwise. Drugs are bad and we are going after them.[2] Twelve days later, in a speech delivered at the Department of Justice, the President followed with an "unshakable" commitment "to do what is necessary to end the drug menace" and "to cripple the power of the mob in America."[3] He cited the "unqualified success" of the Miami Task Force on Crime and Drugs as a model to build on.[4]

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[1] Wisotsky, *Crackdown: The Emerging "Drug Exception" to the Bill of Rights*, 38 Hastings L. J. 889 (1987); Wisotsky (ed.), *The War on Drugs: In Search of a Breakthrough* (Symposium), 11 Nova L. J. 891 (1987); Wisotsky, *The Ideology of Drug Testing*, 11 Nova L. J. 763 (1987).

[2] President's Radio Address to the Nation, 18 Weekly Comp. Pres. Doc. 1249 (Oct. 2, 1982) [hereinafter Radio Address].

It is important to note that President Reagan was not the first to declare War on Drugs. President Nixon had done the same in 1971. In a message to Congress he had described drug abuse as a "national emergency," denounced drugs as "public enemy number one" and called for a "total offensive."[5]

First Drug War or not, the President's statement about the mood of the country seemed accurate. At the time of his October, 1982 speeches, some 3,000 parents groups had already organized nationwide under the umbrella of the National Federation of Parents for Drug Free Youth.[6] Within the Government, the House Select Committee[7] and the Attorney General's Task Force on Violent Crime[8] had urged the President to declare War on Drugs.

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[3] President's Message Announcing Federal Initiatives Against Drug Trafficking and Organized Crime, 18 Weekly Comp. Pres. Doc. 1311, 1313-14 (Oct. 14, 1982).

[4] New York Times, Oct. 15, 1982 at A20.

[5] E. Epstein, Agency of Fear 173, 179 (1977). Nixon consolidated agencies and created DEA as the lead agency in drug enforcement. See note 8.

[6] Gonzales, "The War on Drugs: A Special Report," PLAYBOY Apr. 1982, at 134.

[7] House Select Committee on Narcotics Abuse and Control, H.R. Rep. No. 418, pps. 1-2, 97th Cong., 2d Sess. 50 (1982).

[8] Attorney General's Task Force on Violent Crime, Final Report 28 (1981).

The President's October 14 speech called for and got more of nearly everything:[9] (1) more personnel -- 1020 law enforcement agents for the Drug Enforcement Agency (DEA), Federal Bureau of Investigation (FBI), and other agencies, 200 Assistant United States Attorneys, and 340 clerical staff; (2) more aggressive law enforcement -- creating 12 (later 13) regional prosecutorial task forces across the nation "to identify, investigate, and prosecute members of high-level drug trafficking enterprises, and to destroy the operations of those organizations;" (3) more money -- $127.5 million in additional funding and a substantial reallocation of the existing budget from prevention, treatment, and research programs to law enforcement programs; (4) more prison bed space -- the addition of 1260 beds at 11 federal prisons to accommodate the increase in drug offenders to be incarcerated; (5) more stringent laws -- a "legislative offensive designed to win approval of reforms" with respect to bail, sentencing, criminal forfeiture, and the exclusionary rule; (6) better interagency coordination -- bringing together all federal law enforcement agencies in "a comprehensive attack on drug trafficking and organized crime" under a Cabinet-level committee chaired by the Attorney general; and (7) improved federal-state coordination, including federal assistance to state agencies by training their agents.

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[9] The call for the buildup in the size and scope of the federal drug enforcement bureaucracy also occurred under the Nixon Administration. At the end of June 1968, the Bureau of Narcotics and Dangerous Drugs had 615 agents. By June 1970, this number had increased to over 900, with authorization for at least 300 more agents during 1971. See H.R. Rep. No. 1444, 91st Cong., 2d Sess. 18 reprinted in 1970 U.S. Code Cong. & Admin. News 4566, 4584.

Energized by the hardening attitude toward illegal drugs, the Administration acted aggressively, mobilizing an impressive array of federal bureaucracies and resources in a coordinated, although largely futile, attack on the supply of illegal drugs -- principally cocaine, marijuana, and heroin. The Administration hired hundreds of drug agents and cut through bureaucratic rivalries with greater vigor than any Administration before it. It acted to streamline operations and compel more cooperation among enforcement agencies. It placed the FBI in charge of DEA and gave it major drug enforcement responsibility for the first time in its history.[10] And, as the centerpiece of its prosecutorial strategy, it fielded a network of Organized Crime Drug Enforcement Task Forces in thirteen "core" cities across the nation.[11]

To stop drugs from entering the country, the Administration attempted to erect a contemporary anti-drug version of the Maginot Line: the National Narcotics Border Interdiction System (NNBIS), an intelligence network designed to coordinate radar surveillance and interdiction efforts along the entire 96,000-mile border of the United States. As part of that initiative, NNBIS floated radar balloons in the skies over Miami, the Florida Keys, and even the Bahamas to protect the nation's perimeter against drug smuggling incursions.[12]

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[10] See 28 C.F.R. §§ 0.85(a), 0.102 (1986). Authority for federal drug law enforcement is distributed among several agencies, including the DEA, the Customs Service, the Coast Guard, the FBI, and the IRS. Supporting roles are played by the Immigration and Naturalization Service, the CIA, and the Department of Defense. See National Drug Enforcement Policy Board, "National and International Drug Law Enforcement Strategy" (Jan. 1987).

[11] See Organized Crime Drug Enforcement Task Forces: Goals and Objectives, 11 Drug Enforcement 6 (1984); Maitland, "President Gives Plan to Combat Drug Networks," N.Y. Times, Oct. 15, 1982 § A, at 1, col. 2.

The CIA joined the war effort by supplying intelligence about foreign drug sources, and NASA assisted with satellite-based surveillance of coca and marijuana crops under cultivation.[13] The Administration also initiated financial investigations, aided by computerized data banks and staffed by Treasury agents specially trained to trace money laundering operations.[14] The State Department pressured foreign governments to eradicate illegal coca and marijuana plants and financed pilot programs to provide peasant farmers with alternative cash crops.[15] It also negotiated Mutual Assistance

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[12] See Gibson, "Anti-Smuggling System Would Have CIA Links," Ft. Lauderdale News & Sun-Sentinel, June 18, 1983, § A, at 1, col. 3. See also Office of Technology Assessment, U.S. Congress, "The Border War on Drugs" 33-39 (1987) [hereinafter "Border War"].

[13] See Coates & DeLama, "Satellite Spying on Narcotics Operations Is a Promising Tool for Drug Task Force," Miami Herald, June. 23, 1983, at 11A, col. 1.

[14] For a description of Operation Greenback, the prototype money-laundering investigation, see Financial Investigation of Drug Trafficking: Hearing Before the House Select Comm. on Narcotics Abuse and Control, 97th Cong., 1st Sess. 65 (1981).

[15] See International Narcotics Control: Hearings Before the House Comm. on Foreign Affairs, 97th Cong., 2d Sess. 156 (1982); International Narcotics Trafficking: Hearings Before the Permanent Subcomm. on Investigations of the Senate Comm. on Governmental Affairs, 97th Cong., 1st Sess 201-02 (1981).

Treaties to expose "dirty" money secreted in tax haven nations and to extradite defendants accused of drug conspiracies against the laws of the United States.[16]

The Government also literally militarized what had previously been only a rhetorical war, deploying the armed forces of the United States to "assist" drug enforcement operations The Department of Defense provided pursuit planes, helicopters, and other equipment to federal civilian enforcement agencies, while Navy E-2C "Hawkeye" radar planes patrolled the coastal skies in search of smuggling aircraft and ships.[17] The Coast guard, receiving new cutters and more personnel, intensified its customary task of interdicting drug-carrying vessels at sea. 1981 amendments to the Posse Comitatus Act relaxed the century-old ban on military enforcement of criminal laws and permitted Coast Guard boarding parties to sail on Naval warships serving as "platforms" for Coast Guard interdictions.[18] Finally, for the first time in American history, Navy vessels, including a nuclear-powered aircraft carrier, began directly to interdict -- and in one case fired upon -- drug smuggling ships in international waters.[19] On a purely technical level, the Administration could rightly claim some success in focusing the resources of the federal government in an historically large and single-minded attack on the drug supply.

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[16] See President's Commission on Organized Crime, "America's Habit: Drug Abuse, Drug Trafficking and Organized Crime" 412-19 (1986).

[17] Starita, "Radar Planes to Hunt Drugs in S. Florida," Miami Herald, Mar. 13, 1982, at 1B, col. 5.

[18] Congress has likened the drug smugglers to an invading army, complete with generals, soldiers, and an armada that operates over the unpatrolled coastline and unmonitored airspace of the United States. See Note, "Fourth Amendment and Posse Comitatus Act Restrictions on Military Involvement in Federal Law Enforcement," 54 Geo. Wash. L. Rev. 404, 417 & nn. 140-42 (1986).

What were the results of this extraordinary enforcement program? It set new records in every category of measurement -- drug seizures, investigations, indictments, arrests, convictions, and asset forfeitures. For example, DEA, FBI and Customs seized nearly one-half billion dollars in drug-related assets in FY 1986.[20] DEA arrested twice as many drug offenders in 1986 (12,819) as in 1982, and the percentage of arrestees constituting high level traffickers also rose from roughly one-third to one-half.[21] DEA, FBI and other federal agencies seized over 100,000 lbs. of cocaine in FY 1986.[22] From the end of 1980 to June 30, 1987, the prison population (counting felonies only) soared from 329,021 to 570,519. Roughly 40% of new prison inmates now go in for drug offenses. In recognition of this boom, the FY 1989 budget submission of the President seeks a 48% increase for the U.S. Bureau of Prisons in order to accommodate an anticipated increase in prisoners from 44,000 today to 72,000 by

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[19] Stein, "Naval Task Force Enlists in Drug War," Miami Herald, Aug. 24, 1983, at 13A, col. 4; Balmaseda, "Navy Bullets Riddle Pot-Smuggling Ship," Miami Herald, July 17, 1983, at 1A, col. 5.

[20] National Drug Policy Board, "Federal Drug Enforcement Progress Report, 1986" Exhibit II-2, pp. 19-20 [hereinafter "Progress Report"].

[21] Id., Exhibit II-11, p. 35.

[22] Id., Exhibit III-1, pp. 74-78.

1995.

Despite the Administration's accumulation of impressive statistics, domestic marijuana cultivation took off and the black market in cocaine grew to record size. In 1980, the supply of cocaine to the U.S. was estimated at 40 metric tones; by 1986 it had risen to 140 tons. As a result of this abundant supply and a more-or-less stable pool of buyers, prices fell dramatically. In 1980, a kilo of cocaine cost $50,00-$55,000 delivered in Miami; by 1986, it had fallen to the range of $12,000-$20,000; $14,000 was typical for much of 1988. In 1980-81, a gram of cocaine cost $100 and averaged 12% purity at street level. By 1986, the price had fallen to as low as $80 ($50 in Miami), and the purity had risen to more than 50%.[23] Around the nation, crack was marketed in $5 and $10 vials to reach the youth and low income markets.[24] More than 22 million Americans report having tried cocaine; and roughly 5.8 million report having used it during the month preceding the 1985 National Household Survey.[25] Cocaine-related hospital emergencies rose from 4,277 in 1982 to 9,946 in 1985, to more than 26,000 in 1987.[26]

As if to mock the aggressive efforts of the War on Drugs, this rapid market growth occurred in the face of President Reagan's doubling and redoubling of the federal anti-drug enforcement budget from $645 million in fiscal year 1981 to over $4 billion in fiscal year 1987.[27] Resources specifically devoted to interdiction rose from $399 million to $1.3 billion, one third of the current budget; and military assistance rose from $5 million to $405 million,[28] including the provision of (the services of) Air Force AWACS and Navy E-2C radar planes; Army Black Hawk helicopters used in Customs pursuit missions; and the Custom's Service's own purchases of P-3 radar planes, Citation jet interceptors, and Blue Thunder interceptor boats. DEA personnel rose from 1940 in 1981 to 2875 special agents in 1988, with more on request for FY 1989, along with a 47-position air wing for DEA.

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[23] Data on price, purity and supply are taken from the annual reports of the National Narcotics Intelligence Consumers Committee called "The Supply of Illicit Drugs to the U.S. from Foreign and Domestic Sources."

[24] "Progress Report" at 7.

[25] Id. at 5.

[26] Id. at 6. 1987 data from 1987 NNIC Report.

This budgetary expansion seems all the more remarkable when compared to the anti-drug budget for fiscal year 1969 of $73.5 million.[29] Commenting specifically upon the interdiction budget, the Office of Technology Assessment concluded:

> Despite a doubling of Federal expenditures on interdiction over the past five years, the quantity of drugs smuggled into the United States is greater than ever . . . . There is no clear correlation between the level of expenditures or effort devoted to interdiction and the long-term availability of illegally imported

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[27] Congressional Research Service, Library of Congress, "Drug Abuse Prevention and Control: Budget Authority for Federal Programs," FY 1986 - FY 1988 [IP334D] (Feb. 27, 1987). The budget dropped to 3 plus billion in FY 88.

[28] Leen, "Drug War Proving a Costly Failure," Miami Herald,Sept. 11, 1988 at 18A.

[29] Select Comm. on Narcotics Abuse and Control, 95th Cong., 2d Sess., Congressional Resource Guide to the Federal Effort on Narcotics Abuse and Control 250 (Comm. Print 1976).

drugs in the domestic market.[30]

The social "return" on the extra billions spent during that time has been a drug abuse problem of historic magnitude, accompanied by a drug trafficking parasite of international dimensions.

This latter point is crucial. It is not simply that the War on Drugs has failed to work; it has in many respects made things worse. It has spun a spider's web of black market pathologies, including roughly 25% of all urban homicides, widespread corruption of police and other public officials, street crime by addicts, and subversive "narcoterrorist" alliances between Latin American guerrillas and drug traffickers.[31] In the streets of the nation's major cities, violent gangs of young drug thugs engage in turf wars and open shoot-outs with automatic rifles.[32] Innocent bystanders are often shot. Corruption pervades local police departments and foreign governments. Some Latin American and Caribbean nations have been effectively captured by drug traffickers.[33] Where capture is incomplete, intimidation reigns: one third of the Colombian Supreme Court was assassinated in a (suspected) narco-terrorist raid. An estimated 60 Colombian justices have been murdered in a recent five-year period.[34]

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[30] "Border War" at 3.

[31] These phenomena are described in some detail in Breaking the Impasse in the War on Drugs, Chs. 7-9.

[32] "The Drug Gangs," Newsweek, March 28, 1988 at 20.

[33] The leader of Panama, General Manuel Noriega, is currently under two separate federal indictments for drug trafficking offenses. The Chief Minister and the Commerce Minister of the Turks and Caicos were convicted in the U.S. of drug smuggling charges in 1985. Top officials in Haita, Honduras, and Nicaragua are also under investigation in the U.S. Oppenheimer, "U.S. urged to step up drug fight," Miami Herald, Feb. 14, 1988 at 14A. George Baron, a U.S. Government witness in the Carlos Lehder Rivas cocaine conspiracy trial, testified that he paid $3 to $5 million in bribes to Bahamian Prime Minister Lynden O. Pindling. Baron testified that he paid Pindling

Of course, these pathologies were foreseeable. They are a function of money. Drug law yields to a higher law: the law of the marketplace, the law of supply and demand. The naive attack on the drug supply through an aggressive program of enforcement at each step -- interdiction, arrest, prosecution, and punishment -- results in what Stanford Law School Professor Herbert Packer has called a "crime tariff."[35] The crime tariff is what the seller must charge the buyer in order to monetize the risk he takes in breaking the law. It is in short a premium for taking risks. The criminal law thereby maintains hyper-inflated prices for illegal drugs in the black market.

For example, an ounce of pure pharmaceutical cocaine at roughly $80, just under $3.00 per gram, becomes worth about $4480 if sold in the black market at $80 per diluted gram (at 50% purity). The crime tariff is thus $4,400 per ounce. This type of law enforcement succeeds to some unknown extent in making drugs less available -- to the extent (probably slight) that demand is elastic or sensitive to price. But because the crime tariff is paid to lawbreakers rather

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$15 for each pound of marijuana smuggled through the Bahamas to protect the boats from Bahamian police. AP, Miami Herald, Feb. 17, 1988 at p. 10 A.

[34] See Bin, "Drug Lords and the Colombian Judiciary: A Story of Threats, Bribes and Bullets," 5 Pacific Basin L.J. 178 (1986).

[35] H. Packer, The Limits of the Criminal Sanction 277-82 (1968).

than the Government, it pumps vast sums of money into the black market, more than $100 billion per year by government estimate.[36] The flow of these illegal billions through the underground economy finances or supplies the incentives for the pathologies described above: homicides, street crime, public corruption and international narcoterrorism. If these phenomena were properly costed out, one might well conclude that the War on Drugs makes a net negative contribution to the safety, well being and national security interests of the American people.

Confronted by these threatening developments, both the public and the politicians predictably react in fear and anger. The specter of uncontrolled and seemingly uncontrollable drug abuse and black marketeering lead to frustrated reaction against the drug trade. The zeal to "turn the screw of the criminal machinery -- detection, prosecution and punishment -- tighter and tighter"[37] leads directly to the adoption of repressive and punitive measures that aggrandize governmental powers at the expense of individual rights.

This reactive, almost reflexive growth of governmental power and the correlation squelching of personal liberty occur as two closely related, if not inseparable, phenomena: (1) the Government's sustained attack, motivated by the perceived imperatives of drug enforcement, on traditional protections afforded to criminal defendants under the Bill of Rights, and (2) the gradual but perceptible rise of "Big Brotherism" against the public at large in the form of drug testing, investigative detention, eavesdropping, surveillance, monitoring, and other intrusive enforcement methods.

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[36] House Select Committee on Narcotics Abuse and Control Annual Report for the Year 1984, H.R. Rep. No. 1199, 98th Cong., 2d Sess. 9 (1985).

[37] Albernaz v. United States, 450 U.S. 333, 343 (1981).

It may be difficult for those not familiar with criminal law and procedure to understand the degree to which the War on Drugs has disempowered the criminal defendant, especially in drug cases. Perhaps by focusing on a few of the most important of the many restrictions that have been imposed, one may begin to appreciate the severity of the crackdown on the rights of those accused of crime.

First, let us consider pre-trial detention. It is important to understand that in the U.S. the law has always favored pre-trial release to reinforce the presumption of innocence and to allow a defendant to aid counsel in his defense. The Eighth Amendment to the United States Constitution prohibits excessive bail; and while the cases do not establish a "right" to bail, the law has evolved as if there were a presumptive right to pre-trial release on bail (or other conditions) except in capital cases where "the proof is evident or the presumption great." This was changed radically by the Comprehensive Crime Control Act of 1984,[38] which not only authorized pre-trial detention but created a statutory presumption in favor of it in any case in which, inter alia, the defendant is charged with a drug offense punishable by ten years or more in prison.[39] Although the presumption is rebuttable, in the first seven months under the act, the Government won 704 motions for pre-trial detention while defendants won only 185.[40] Pretrial detention is a severe blow to the morale of a defendant and to his ability to assist in the preparation of his defense.[41]

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[38] Pub. L. No. 98-473, Tit. II, ch. 1, § 203(a), 98 Stat. 1976 (1984) (codified at 18 U.S.C. § 3142)(Supp. 1986).

[39] 18 U.S.C. § 3142(e) (Supp. 1986).

Another major erosion in the rights of defendants is the more permissive use of illegally seized evidence. Since 1914, the Fourth Amendment to the U.S. Constitution has been interpreted to exclude from use in court evidence obtained by federal law enforcement authorities in an illegal search and seizure.[42] Many states voluntarily adhered to that ruling, and in 1961 the remaining states were required to do so by the decision of the Supreme Court in Mapp v. Ohio.[43] But under the relentless pressure of drug prosecutions and the frequent attempts of Congress to repeal or restrict the exclusionary rule, the Courts have whittled away at the protections afforded to individual privacy.

Notwithstanding the independence of the judicial branch, the Courts have in effect joined the war on drugs. Most notably, the U.S. Supreme Court gave its approval to just about every challenged drug enforcement technique. For example, the Court upheld the power of drug agents to use the airport drug courier profile to stop, detain and question citizens without probable cause;[44] to subject a traveller's luggage to a sniffing examination by drug detector dogs without probable cause;[45] to make warrantless searches of automobiles and closed containers therein;[46] to conduct surveillance of suspects by placing transmitters or beepers in containers in vehicles;[47] to search at will without cause ships in inland waterways;[48] and to obtain a search warrant based on an undisclosed informant's tip.[49] The Supreme Court also adopted a "good-faith exception" to the exclusionary rule for evidenced seized in searches made pursuant to defective warrants.[50] It authorized warrantless searches of open fields and barns adjacent to a residence.[51] It significantly enlarged the powers of police to stop, question and detain drivers of vehicles on the highways on suspicion less than probable cause[52] or with no suspicion at all at fixed checkpoints or road blocks.[53] The Court also validated warrantless aerial surveillance, that is airplane overflights of private property,[54] the warrantless search of a motor home occupied as a residence,[55] and the warrantless search of the purse of a public school student.[56] In the realm of search and seizure, there is hardly a drug case that the Government failed to win. Indeed, the Supreme Court in Albernaz apparently placed its imprimatur on the turn-the-screw approach of the U.S. Congress. Thus, the crackdown mentality prevails not only in the political realm but, to use Madison's phrase, in "the least dangerous branch" as well.

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[40] Kennedy, "Foreword to Symposium on the Crime Control Act of 1984," 22 Am. Crim. L. Rev. vi, viii n. 4 (1985).

[41] Wald, "Pretrial Detention and Ultimate Freedom: A Statistical Study," 39 N.Y.U. L. Rev. 631 (1964).

[42] Weeks v. United States, 232 U.S. 383 (1914).

[43] 367 U.S. 643 (1961).

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[44] Florida v. Royer, 460 U.S. 491, 493 (1983); see also United States v. Montoya, 473 U.S. 531 (1985); Florida v. Rodriguez, 469 U.S. 1, 5 (1984). Drug courier profiles are based on an informal compilation of traits commonly associated with drug smugglers; they have been criticized for allowing impermissible intrusions on fourth amendment rights based solely on an agent's "hunch." See Note, "Drug Courier Profiles in Airport Stops," 14 S.U.L. Rev. 315, 316-17 & n. 23 (1984). For further criticisms, See Note, "Search and Seizure: Defining the Outer Boundaries of the Drug Courier Profile," 17 Creighton L. Rev. 973 (1985).

[45] United States v. Place, 462 U.S. 696, 706 (1983).

[46] United States v. Ross, 456 U.S. 798, 821 (1982); see also Colorado v. Bertine, 107 S.Ct. 738 (1987).

[47] United States v. Knotts, 460 U.S. 276, 282 (1983).

[48] United States v. Villamonte-Marquez, 462 U.S. 579, 593 (1983).

[49] Illinois v. Gates, 462 U.S. 213 (1983). Gates replaced the principles of probable cause established in Aguilar v. Texas, 378 U.S. 108 (1964) and Spinelli v. United States, 393 U.S. 410 (1969) with a more loosely structured "totality of the circumstances" test. Gates, 462 U.S. at 230.

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[50] United States v. Leon, 468 U.S. 897, 905 (1984). To similar effect are Illinois v. Krull, 107 S.Ct. 1160 (1987), and Maryland v. Garrison, 107 S.Ct. 1013 (1987). For criticism of the good faith exception, see 1 W. LaFave, Search and Seizure: A Treatise on the Fourth Amendment § 1.3(c)-(d), at 51, 58-59 (1987) (arguing that the Leon Court overestimated the costs of adherence to the exclusionary rule based on "intuition, hunches, and occasional pieces of partial and often inconclusive data").

[51] United States v. Dunn, 107 S.C. 1134 (1987) (barn); Oliver v. United States, 466 U.S. 170 (1984) (open fields).

[52] United States v. Sharpe, 470 U.S. 675 (1985).

[53] Texas v. Brown, 460 U.S. 730 (1983).

[54] California v. Ciraolo, 106 S.Ct. 1809, 1813 (1986).

[55] California v. Carney, 471 U.S. 386, 390 (1985).

[56] New Jersey v. T.L.O., 469 U.S. 325, 333 (1985).

One further example of the crackdown atmosphere prevailing in the U.S. comes from the Anti-Drug Abuse Act of 1986,[57] in which Congress not only created new crimes but added to the penalties which already existed. The effect of the Act is that drug crimes now rank among the most seriously punished offenses in the United States Criminal Code. For example, the Act provides mandatory minimum penalties of five and ten years in prison depending upon drug and weight involved; in the case of possession with intent to distribute five kilograms of cocaine, the penalty is a minimum of ten years up to a maximum of life imprisonment. Even as little as five grams of cocaine base require not less than five years in prison and a maximum of forty years. In both cases, the range of penalties rises to a minimum of 20 years to maximum of life if death or serious bodily injury results from the use of such substances. It should be emphasized that these penalties apply to first time drug offenders; those with a prior state or federal drug conviction must receive a mandatory life term under these circumstances.

The facts that these penalties are so severe, more stringent in fact than sentences typically meted out to robbers or rapists,[58] illustrates one of the themes of this statement: people in the U.S. are so fearful and angry about their inability to contain drug trafficking that they are resorting to extremist, desperation measures. More than one public official has proposed simply shooting suspected drug-carrying planes out of the sky. The atmosphere is perhaps best conveyed by the judicial opinion of a respected federal judge in Miami who, in an order denying bail pending appeal, condemned drug dealers as "merchants of misery destruction and death" whose greed has wrought "hideous evil" and "unimaginable sorrow" upon the nation. Their crimes, he wrote, are "unforgivable."[59] And if drug crimes are literally "unforgivable," traditional constitutional and statutory protections for individual rights can be discounted or discarded. One Congressman in fact complained about the extent to which legal protections interfered with the prosecution of drug cases: "[I]n the War on Narcotics we have met the enemy and he is the U.S. code. I have never seen such a maze of laws and hangups . . . ."[60] In that spirit, and the spirit of the angry judge just quoted, the punitive measures I have described, along with dozens of others,

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[57] Pub. L. No., 99-750, reprinted in 1986 U.S. Code Cong. & Admin. News (No. 10A) (codified as amended in scattered sections of U.S.C.).

[58] A not untypical example comes from a prominent 1988 news story. Larry Singleton had been convicted of raping a teenager and hacking off the arms of a teenager between wrist and elbow. He was convicted in California and given the maximum sentence of 14 years and served 8. In Florida, a person convicted of possession of 400 grams of cocaine or other similar drug trafficking offense would

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receive a non parolable mandatory term of 15 years. With typical gain time and work credits, he might serve approximately 7 years in prison.

[59] United States v. Miranda, 442 F. Supp. 786, 795 (S.D. Fla. 1977).

[60] Financial Investigation of Drug Trafficking: Hearings Before the House Select Comm. on Narcotics Abuse and Control, 97th Cong., 1st Sess. 58 (1981) (statement of Congressman Hutto).

such as forfeiture of defense attorney's fees[61] have become "logical" measures in an endless cycle of crackdowns and failures.

Perhaps if these repressive laws applied only to drug defendants, who could be dismissed as an alien "them," few would care and fewer still would protest. But this kind of reactionary force cannot be contained, cannot apply only to those accused of drug crime. In fact, the tentacles of drug enforcement have already spread out to reach into the lives of ordinary people, not just to those involved in the drug underworld. These intrusions into the lives of civilian society take many forms. One of the most obvious is the rapid proliferation of mandatory drug testing of employees and job applicants in the U.S. Civil Service[62], state and local civil services, and in the private sector as well. Some 40% of Fortune 500 companies now subject their applicants or employees to urinalysis.[63]

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[61] United States v. Caplin & Drysdale, 814 F.2d 905 (4th Cir. 1987), cert. granted __ S.Ct. ___ (1988). Contra: United States v. Monsanto, __ F.2d __ (2d Cir. 1988).

[62] President's Message Announcing the Goals and Objectives of the National Campaign Against Drug Abuse, 22 Weekly Comp.Pres. Doc. 1040, 1041 (Aug. 4, 1986).

[63] General Dynamics, General Motors, Greyhound, E.F. Hutton, IBM, Mobil, The New York Times, The Teamsters, and United Auto Workers are but a few of the enterprises that have recently instituted some type of workplace drug testing. Ross, "Drug Testing at Work Spreading -- and Likely to Spread Further," L.A. Daily J., June 6, 1985, at 4, col. 3. See generally, "Testing for Drugs in the American Workplace," 11 Nova L. Rev. 291 (1987); Wisotsky, "The Ideology of Drug Testing," 11 Nova L. J. 763 (1987).

One rationale for requiring that urinalysis be predicated upon individual suspicion is the not-unlikely possibility of a false positive result:

> Two Navy doctors were almost drummed out of the service

Government surveillance is on the increase in the form of wiretaps and the maintenance of 1.5 million or more names in NADDIS, a drug investigative data bank. On a more prosaic level, the War on Drugs hampers the mobility of travellers, who are subjected to road blocks, detained for questioning at airports, and whose luggage can be diverted for sniffing by drug detector dogs.

One of the latest repressive anti-drug initiatives to emerge from Washington is called "zero tolerance," begun by the Customs Service on March 21. It means, in a nutshell, punishing drug users to promote "user accountability" and to reduce "the demand side of the equation." One manifestation of this policy occurs in the effort to promote federal criminal prosecution of persons found in possession of personal use of amounts of drugs who formerly would have escaped prosecution or been referred to local authorities for prosecution. On March 30, 1988 Attorney General Meese sent a memorandum to all United States Attorneys encouraging the selective prosecution of "middle and upper class users" in order to "send the message that there is no such thing as `recreational' drug use...."

More widaly known is the seizure and forfeiture of cars, planes or of boats of persons found in possession of even trace amounts of illegal drugs; these forfeited assets in effect impose massive fines

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> [in 1984] because they tested positive for morphine, the result of having eaten too many poppy seed bagels. Indeed, the Navy program has seen huge errors -- over 4,000 men and women were recalled at full back pay [in 1985] because they were discharged on the basis of a [false positive].

Ross, supra.

far greater than would ordinarily be imposed upon a criminal conviction for drug possession; but as civil forfeiture is in rem, no conviction or prosecution is required at all. Some examples: On April 30, the Coast Guard boarded and seized the motor yacht Ark Royal, valued at $25 million, because 10 marijuana seeds and two stems were found abroad. Public criticism prompted a return of the boat upon payment of $1600 in fines and fees by the owner. The 52 foot Mindy was impounded for a week because of cocaine dust in a rolled up dollar bill. The $80 million oceanographic research vessel Atlantis II was seized in San Diego when the Coast Guard found .01 ounce of marijuana in a crewman's shaving kit. It was returned also. But a Michigan couple returning from a Canadian vacation lost the wife's 1987 Cougar when Customs agents found 2 marijuana cigarettes in the pocket of her husband. No charges were filed, but the car was kept by the Government. In Key West, Florida, David Phelps, a shrimp fisherman, lost his 73 foot shrimper to the Coast Guard who found 3 grams of cannabis seeds and stems abroad. Under the law, the boat is forfeitable whether or not Phelps had any responsibility for the drugs. Three weeks later, the boat had not been returned. There are many other ways, too numerous to mention in this statement, that the War on Drugs has choked off civil liberties in the U.S.

In 1987, the United States celebrated the bicentennial of its Constitution. The framers of the Constitution were animated by the spirit of William Pitt's dictum that "unlimited power is apt to corrupt the minds of those who posses it."[64] They therefore created a constitutional structure in which governmental power was limited in the first instance and constrained in the second by the system of checks and balances. The Bill of Rights, the first 10 amendments to the Constitution, were added in 1791 to further secure personal freedom from governmental oppression. The War on Drugs has substantially undermined the American tradition of limited government and personal autonomy. Since the early 1980's, the prevailing attitude, both within Government and in the broader society, has been that the crackdown on drugs is so imperative that extraordinary measures are justified. The end has came to justify the means. The result is that Americans have significantly less freedom than they did only five or six years ago.

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[64] Speech, Case of Wilkes (Jan. 19, 1770).

The Latest Developments in 1988: Polarization

Election year politics continues to ratchet the War on Drugs machinery tighter and tighter. In June the Administration declared its goal of a "drug free America."[65] During the month of April, the Senate voted 93-0 to adopt the Anti Drug Abuse Act of 1988, creating a $2.6 billion special reserve fund for anti-drug programs over and above the regular annual budget of 3-plus billion dollars. (As noted above, the regular budget represents a manifold increase in the level of funding that prevailed when the war on drugs was declared.) The frustration of Congress with drug-producing nations of Latin America, crystallized by the stalemate with General Noriega in Panama, has produced a number of controversial proposals involving the threat of sanctions[66] and the use of military force to destroy coca crops or to capture fugitives from U.S. drug charges. Secretary Carlucci's opposition to arrest powers for the military services may tone down the final bill, but an expanded military surveillance role seems likely. At the state level, the National Guard has already been deployed on anti-drug search and destroy missions.

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[65] National Drug Policy Board, "Toward a Drug Free America" (1988).

The President on April 19 "call[ed] upon the House and Senate to vote promptly on my bill providing for capital punishment when a death results from drug dealing, and when a . . . law enforcement officer is murdered." In the latest piece of fundamentalist style anti-drug zealotry, the House on September 22 voted 375-30 to adopt capital punishment, for a drug exception to the exclusionary rule, to deny college student loans to anyone convicted of possessing drugs, to impose without trial up to $10,000 in "civil fines" for a person caught in possession of drugs, and to impose a mandatory five-year prison sentence on anyone convicted of possession of crack cocaine. Other "zero tolerance" style bills abound. A House Republican Task force has introduced a bill calling for confiscation of 25% of the adjusted gross income and net assets of anyone caught possessing illegal substances. It would also cut off federal highway funds to states that do not suspend drivers' licenses of persons convicted of using drugs.[67] As we get closer to the November election, one can predict with confidence that more of these proposals will surface and that their extremist nature will increase.

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[66] In February, the House Foreign Affairs Committee Task Force on International Narcotics Control demanded that the State Department impose sanctions against Colombia, Peru, Bolivia and other nations in order to force them to intensify their drug enforcement efforts.

[67] "The Drug Enforcement Report," June 23, 1988, p.2.

But at the same time there is movement in the opposite direction. Respected journalists and other opinion leaders have begun to break ranks with the War on Drugs, in some cases suggesting that it be abandoned altogether. Here are some notable examples. David Boaz, Vice President for public policy at libertarian-oriented CATO Institute, wrote an op-ed piece for the New York Times (March 17) "Let's Quit the Drug War." In it he denounced the war on drugs as "unwinnable" and destructive to other values such as civil liberties and advocated a "withdrawal" from the war. Edward M. Yoder, Jr. of the Washington Post Writers Group called the war on drugs "dumb" and compared it to the prohibition of alcohol for "encouraging and enriching mobsters" (March 4, 1988). On March 10, 1988, Richard Cohen of the Los Angeles Times Syndicate published a piece endorsing the idea of a plan for the government distribution of drugs in order to "recognize the drug problem is with us to stay -- a social and medical problem, but not necessarily a law enforcement one. We've been making war on drugs long enough. It's time we started making sense instead." By May and June, articles of this type became a staple item in newspapers all over the country as editors hopped aboard the "legalization" bandwagon.

This sample of articles shows the emergence of a significant body of opinion opposed to the war on drugs. What is perhaps even more significant is that the opposition transcends the liberal/ conservative split. Traditionally, conservatives have advocated strict law enforcement and liberals have been identified with a permissive approach to the drug issue. Now highly respected conservative spokesmen have also begun to dissent from the War on Drugs.

Even before the recent spate of articles described above, prominent conservative columnist William F. Buckley, Jr. had reversed his position and advocated the legalization of drugs as the only effective course of governmental action. Nobel Prize-winning economist Milton Friedman has made public statements advocating more market-oriented approaches to the regulation of drugs. National Review, the most prominent organ of conservative opinion, through its editor Richard Vigilante, published a piece (Dec. 5, 1986) exposing the Anti Drug Abuse Act of 1986 as a manifestation of public panic and criticizing the intrusiveness of drug testing and other enforcement measures. He also rejected the war on drugs as intolerant and politically unwise: "Embracing the drug hysteria requires a rejection of essential conservative principles." In the same issue of NR is an article by Richard C. Cowan entitled "How the Narcs Created Crack" arguing as follows: "Any realistic approach to the drug problem must begin with the legalization of small scale cultivation and sale of marijuana so that it is separated from the other, more dangerous drugs. . . . We need not fear that if we stop the lying and hypocrisy, the American people are going to destroy themselves with drugs."

This debate has captured the attention of the mainstream media.[68] Clearly, the challenge to the monopoly status of the War on Drugs is gaining ground. Nothing approaching this level of dissent has been seen or heard since the War on Drugs started.

The dissent has also begun to spill over to the political sector. For example, the ABA Journal (Jan. 1, 1988) reported that the New York County Lawyers Association Committee on Law Reform published a report advocating the decriminalization of heroin, cocaine and marijuana. New York State Senator Joseph L. Galiber, from a district in the drug-ravaged Bronx, introduced on April 18 a bill in the New York State legislature to decriminalize the possession, distribution, sale, and use of all forms of controlled substances under the aegis of a State Controlled Substance Authority. At a speech at the National Conference of Mayors and again on a May 10, 1988, broadcast of ABC's "Nightline," the Mayor of Baltimore called for congressional hearings to study the issue. Other mayors and a few congressmen supported him. And, surprisingly, Congressman Charles Rangel, Chairman of the House Select Committee on Narcotics Abuse and Control, scheduled a one-day hearing for September 29, 1988, clearly inadequate for the task at hand, yet perhaps a harbinger of the future. Even if nothing constructive can emerge amidst election year maneuvering, at least the genie of change is out of the bottle.

There are also pressures beginning to come from abroad. For example, the Attorney General of Colombia said in a telephone interview with the Miami Herald (February 23, 1988) that Colombia's battles against drug trafficking rings have been a failure, calling it "useless." He suggested that legalizing the drug trade is something that the government "may have to consider" in the future. The Economist Magazine ran a cover story (April 2-8) called "Getting Gangsters Out of Drugs," advocating the legalized and taxed distribution of controlled substances. It followed up with similar commentaries on May 21 and June 4. El Pais, the most influential Spanish newspaper, also recommended "La legalizacion de la droga" in an editorial (May 22, 1988).

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[68] Time Magazine ran a cover story on the debate called "Thinking the Unthinkable" (May 30, 1988). Newsweek did a similar piece. The New York Times and the Miami Herald both ran front page stories on the same subject in May.

What accounts for this trend? Negative experience with the War on Drugs certainly plays a role. In the Structure of Scientific Revolutions, Thomas S. Kuhn argued that "the process by which a new candidate for paradigm replaces its predecessors" occurs "only after persistent failure to solve a noteworthy puzzle has given rise to crisis" (pp. 144-145). There is little doubt that the perception that the War on Drugs is a failure at controlling drug supply has spread significantly. Uncritical acceptance of the War on Drugs is no longer possible. And the perception that it has negative side effects, breeding crime, violence and corruption, has spread even to the comic pages of the daily newspapers.[69] In a more serious vein,

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[69] The syndicated strip "Bloom County," for example, satirized the issue on at least two separate occasions. The April 18, 1988 strip portrayed a scenario in which a lobbyist for smugglers makes contributions to anti-drug candidates for political office as a way to keep drug prices high. "Nothing makes us madder than some liberal talking drug legalization."

Ted Koppel's "Nightline" broadcast a special 3-hour "National Town Forum" on the subject of legalization. Perhaps we have already reached Kuhn's stage of "persistent failure and crisis," in which the war on drugs has been dislodged as the only conceivable paradigm for the control of drugs in the U.S. What now should be done?

TOWARD A NEW BEGINNING IN DRUG CONTROL

One historically tested model of exploring policy reform is the appointment of a National Study Commission of experts, politicians and lay leaders to make findings of fact, canvass a full range of policy options, and recommend further research where needed. The precedent set by the National Commission on Marijuana and Drug Abuse in the early 1970's offers a model that might usefully be emulated in many respects. At the very least, a National Commission performs a vital educational function: its public hearings and attendant media coverage inform the public, bringing to their attention vital facts and a broader array of policy options. The level of public discourse is almost certain to be elevated. Only those who prefer ignorance to knowledge could possibly oppose the commission process.

What should be the agenda of such a commission? Its overriding goal should be to develop policies directed toward the objectives of (1) reducing drug abuse and (2) reducing the black market pathologies resulting from the billions in drug money generated by drug law enforcement. In pursuit of these dual goals, the commission's study might benefit from adherence to the following five points:

I. DEFINE THE DRUG PROBLEM

What exactly is the problem regarding drugs in the U.S? The lack of an agreed-upon answer to this question is one of the primary sources of incoherence in present law and policy. People now speak of "the drug problem" in referring to at least five very different phenomena: (1) the mere use of any illegal drug; (2) especially by teenagers; (3) the abuse of illegal drugs, i.e., that which causes physical or psychological harm to the user; (4) drug-induced misbehavior that endangers or harms others, e.g., driving while impaired; and (5) drug trafficking phenomena (crime, violence and corruption) arising from the vast sums of money generated in the black market in drugs. This confusion in the very statement of the problem necessarily engenders confusion in solving it. The "drug problem" as Edward Brecher reminds us in his classic Licit and Illicit Drugs is itself a problem. Therefore, it does not and cannot lead to the formulation of useful solutions. It would be a real breakthrough if the Congress or the next President would generate a meaningful statement of the "drug problem." Otherwise, we are condemned to confirm the truth of Eric Sevareid's quip that the chief cause of problems is solutions.

II. STATE YOUR GOALS

A creative definition or redefinition of the drug problem would of itself carry us toward a (re)statement of goals. Rational policy-making is impossible without a clear articulation of the goals sought to be achieved. Part of that impossibility arises from the inconsistency between, for example, pursuit of existing goal number one by an attack on the drug supply and pursuit of goal number five, the suppression of drug money. Pursuit of the first creates a crime tariff which makes pursuit of the last more or less impossible. Instead, the result of drug enforcement is a black market estimated by the government to be over $100 billion per year, money that funds or gives rise to homicidal violence, street corruption by addicts, corruption of public officials and international narco-terrorism. It is therefore essential to distinguish between problems arising from drugs and problems arising from drug money. For example, how much criminality is attributable not to the psychopharmacology of drugs but to the excessive prices intentionally caused by the prohibition of drugs? Rational policy makers have to distinguish between the two and acknowledge the trade-offs between the two lines of attack.

III. SET REALISTIC AND PRINCIPLED PRIORITIES BASED ON TRUTH

The suppression of drugs as an end in itself is frequently justified by arguments that drugs cause addiction, injury and even death in the short or long run. Granted that all drug use has the potential for harm, it is clear beyond any rational argument that most drug use does not cause such harm. Notwithstanding DEA Director John Lawn to the contrary ("Drugs are illegal because they are bad"), drugs are not harmful per se. Exposure to drugs is not the same as exposure to radioactive waste.[70] Rather, the overwhelming majority of incidents of drug use are without lasting personal or societal consequence, just as the overwhelming majority of drinking causes no harm to the drinker or to society.

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[70] Truth-based legislation will also have to acknowledge that "recreational" drugs also have beneficial uses, most notably medicinal ones. Respectable authorities in the U.S. and abroad endorse heroin for pain relief for terminally ill patients. Frances Young, the chief administrative law judge of DEA, recommended this summer that marijuana be re-classified to permit doctors to prescribe it for relief of nausea from chemotherapy and for other purposes. His opinion concludes that marijuana is "far safer than many foods we commonly consume" and that its medical benefits are "clear beyond any question."

Accepting the truth of that premise means that not all drug use need be addressed by the criminal law, and that society might actually benefit from a policy of benign neglect respecting some forms of drug use. I have in mind the Dutch model, where nothing is legal but somethings are simply ignored, cannabis in particular. NORML estimates that there are approximately one-half million arrests per year for marijuana, almost all for simple possession or petty sale offenses. Depending upon the age of consent chosen, most of these arrests could be eliminated from the criminal justice system, thereby achieving a massive freeing of resources for the policing of real crime.

Because we live in a world of limited resources, it is not possible to do everything. It is therefore both logical and necessary to make distinctions among things that are more or less

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Judge Young had previously recommended that MDMA ("ecstasy") be removed from Schedule I and be made legally available to psychiatrists for use in treating their patients.

Medical uses are not the only beneficial effects of drugs. An AP wire from, Frankfurt, West Germany reported that the Air Force allows its pilots to take Dexedrine "so that they are able to fly when they haven't gotten enough sleep or don't feel fit enough." Hundreds of thousands of "drug abusers" similarly stimulate themselves with amphetamines and cocaine. Over a century ago, Sigmund Freud discovered in self experiments that moderate doses (1/10 gram) of cocaine improved his muscular strength and reaction time. See Byck, Cocaine Papers: Sigmund Freud (New York: New American Library, 1974) 98, 103.

important. I have in mind at least five basic dichotomies: (1) drug use by children (top priority) versus drug use by adults (low priority); (2) marijuana smoking (low priority) versus use of harder drugs (higher priority); (3) public use of drugs (high priority) versus private use of drugs at home (low priority); (4) drug consumption (no priority) versus drug impairment (high priority); (5) occasional use (low priority) versus chronic or dependent use (higher priority).

From these general criteria for drug policy, I would commend to the National Commission five specific goals for an effective, principled drug policy:

(1) Protect the Children. I think this priority is self-evident and needs no discussion. I would simply add that this is the only domain in which "zero tolerance" makes any sense at all and might even be feasible if enforcement resources were concentrated on this as a top priority.

(2) Get Tough on the Legal Drugs. It is common knowledge that alcohol (100,000 annual deaths) and tobacco (360,000 annual deaths) far exceed the illegal drugs as sources of death, disease and dysfunction in the U.S. Everyone knows that alcohol and tobacco are big business -- the advertising budget alone for alcohol runs about $2 billion a year -- and, what is worse, the states and federal government are in complicity with the sellers of these deadly drugs by virtue of the billions in tax revenues that they reap.

I am not, however, suggesting prohibition of these drugs. That is wrong in principle and impossible in practice, as experience teaches.

Nonetheless, there are more restrictive measures that can and should be undertaken. One is to get rid of cigarette vending machines so that cigarettes are not so readily available to minors. A second is to require or recommend to the states and localities more restrictive hours of sale. A third is to levy taxes on these products that are consistent with their social costs -- billions of dollars in property damage, disease and lost productivity.[71] Those costs should be financed largely by the sale of these products; at present prices, society is clearly subsidizing those products by providing police, fire, ambulance services for road accidents; medicare and medicaid reimbursement for therapy, surgery, prothesis or other medical care; and many other hidden costs effectively externalized by the industries from smoker and drinker to society as a whole. Precise numbers need to be derived from studies, but I wouldn't be surprised to find cigarettes at, say, $10 a pack and hard liquor at, say, $30-$50 a bottle to be priced more consistently with their true social costs. Such taxes would have the additional salutary effect of reducing the consumption of these dangerous products to the extent that demand is elastic.

(3) Public Safety and Order. Here we need policies directed toward protection of the public from accident and injury on the highway, in the work place and from unruly disruptions in public

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[71] The Research Triangle Institute estimated the annual costs of alcohol abuse to society at $116 billion in 1983. Conference Board, "Corporate Strategies for Controlling Substance Abuse" 13 (Axel ed. 1986). With 1,000 daily deaths from lung cancer and other diseases often preceded by years of medical treatment, there must be billions more in social costs attributable to tobacco.

streets, public transport, parks and other gathering places. Programs specifically tailored to accomplish this more focused goal make a lot more sense than futile and counter productive "zero tolerance" approaches. Street level law enforcement practices need to be reviewed to see to what extent they may actually encourage hustling drugs in the street to avoid arrests and forfeitures that might follow from fixed points of sale.

Promotion of driving and workplace safety require more knowledge. Nothing should be assumed. Drug use, as the Air Force's and Freud's examples show (n. 69), does not automatically mean that a pilot or driver is impaired. Even with marijuana there is ambiguous evidence as to its effect on motor coordination.[72] Responsible research is required.

(4) Protect Public Health. The emphasis here is on the word "public." Policy should be directed toward (1) treatment of addicts on a voluntary basis and (2) true epidemiological concerns such as the use of drugs by pregnant women and the potential for transmission of AIDS by I.V. drug users. Addiction treatment is now shamefully underfunded, with months-long waiting lists in many cities.

Purely individualized risks are not in principle a public health matter and are in any case trivial in magnitude compared to those now accepted from alcohol and tobacco. Judge Young (n. 69) found no known lethal dose of marijuana. Even with cocaine, which has lethal potential, less than 2,000 deaths per year result even though billions of lines or puffs of cocaine are consumed every year. (Other long-term harms may result but are not systematically known at this time.) In any event, harmfulness is not the sole touchstone of regulation; the requirements of goal number five, listed below require considerable deference to individual choice in this domain.

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[72] See Knepper, "Puff the Dangerous Drug," Car and Driver, June 1980 at 43.

(5) Respect the Value of Individual Liberty and Responsibility. The current Administration's goal of a drug-free America, except for children, is both ridiculous -- as absurd as a liquor-free America -- and wrong in principle. This is not a fundamentalist Ayatollah Land after all. A democratic society must respect the decisions made by its adult citizens, even those perceived to be foolish or risky. After all, is it different in principle to protect the right of gun ownership, which produces some ten to twelve thousand homicides per years and thousands more non-fatal injuries? Is it different in principle to protect the right of motorcyclists, skydivers or mountain climbers to risk their lives? Is it different to permit children to ride bicycles which "cause" tens of thousands of crippling injuries and deaths per year? To say that something is "dangerous" does not automatically supply a reason to outlaw it. Indeed, the general presumption in our society is that competent adults, with access to necessary information, are entitled to take risks of this kind as part of the right to life, liberty and the pursuit of happiness. Why are drugs different?

It would be truly totalitarian if the Government could decide these matters. After all, if the Government is conceded to have the power to prohibit what is dangerous, does it not than have the power to compel what is safe? More specifically, if one drug can be prohibited on the ground that it is dangerous to the individual, would it then not be permissible for the government to decree that beneficial doses of some other drug must be taken at specified intervals?

The freedom of American citizens has already been seriously eroded by the War on Drugs.[73] More civil liberties hang in the balance of the 1988 Omnibus Anti-Drug Abuse Act pending in Congress and further legislation in years to come. Is the defense of Americans from drugs to be analogized to the defense of the Vietnamese from Communism, i.e., that it was necessary to destroy the city of Hue in order to save it? The National Commission should give serious weight to this value in its policy recommendations.

IV. FOCUS ON THE BIG PICTURE

Present drug policy suffers from a kind of micro-think that borders on irresponsibility and is sometimes downright silly. This typically manifests itself in proud Administration announcements or reports to Congressional Committees of a new initiative or new accomplishment without regard to its impact on the bottom line. The examples are endless -- a joint strike force with the Government of the Bahamas; shutdown of a source of supply; the Pizza Connection case, the largest organized crime heroin trafficking case ever made by the federal government; a new bank secrecy agreement with the Caymans; a new coca eradication program in Bolivia or Peru, etc.,

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[73] See, Wisotsky, "Crackdown: The Emerging 'Drug Exception' to the Bill of Rights," 38 Hastings L. J. 889 (1987).

etc. But none of these programs or "accomplishments" has ever made any noticeable or lasting impact on the drug supply. Even now, as the Godfather of Bolivian cocaine resides in a Bolivian prison, is there any observable reduction in the supply of cocaine?

The lack of insistence that enforcement programs should make a difference in the real world produces fatuous reports like this 1979 report by GAO to the Congress: "Gains made in Controlling Illegal Drugs, Yet The Drug Trade Flourishes."[74] In what sense is it meaningful to say that gains are made if the bottom line grows worse and worse? This is reprehensible double talk or Newspeak that should not be tolerated by responsible public officials.

The whole drug enforcement enterprise needs to be put on a more business-like basis, looking to the bottom line and not to isolated "achievements" of the war on drugs. In fact, the investor analogy is a good one to use: if the war on drugs were incorporated as a business enterprise, with its profits to be determined by its success in controlling drug abuse and drug trafficking, who would invest in it? Even if its operating budget were to be doubled to $6 billion per year, or doubled again to $12 billion per year, would it be a good personal investment? If not, why is it a good social investment?

This kind of hard-headed thinking is exactly what is lacking and has been lacking throughout the War on Drugs. No attention has been paid to considerations of cause and effect, or to trade-offs, or to cost benefit analysis. New anti-drug initiatives are not subjected to critical questioning: what marginal gains, if any, can be projected from new programs or an additional commitment of resources? Conversely, how might things worsen? For example, many law enforcement officials believe that the Coast Guard's "successful" interdiction of marijuana coming from Jamaica and Colombia in the early 1980's had two negative side effects: the substitution of domestic cultivation of more potent marijuana in California (and throughout the U.S.) and the diversion of smugglers into more compact and more readily concealable cocaine. Was that interdiction initiative therefore truly successful? Weren't those side effects reasonably foreseeable? There are other examples. Drug gangs are probably far more ruthlessly violent today than in the 1970's because they have learned to adapt to aggressive law enforcement methods. The friendly governments of Colombia, Peru, Bolivia are far weaker today, far more corrupt, and far more subject to narcoterrorist subversion because of similar adaptations there by the drug cartel and its associates. Has our national security been thus advanced by the War on Drugs?

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[74] GGD-80-4 (Oct. 25, 1979).

For these reasons, it is important to abjure meaningless, isolated "victories" in the war on drugs and to focus on whether a program or policy offers some meaningful overall impact on the safety, security and well-being of the American people. In this respect, does it really matter that the DEA has doubled the number of drug arrests from 6,000 to 12,000 during the 1980's? Or that the Customs Service has dramatically increased its drug seizures to over 100,000 pounds of cocaine? Or that kingpins like Carlos Lehder Rivas have been convicted and imprisoned for life plus 135 years? Might it not be that the resources devoted to those anti-drug initiatives were not merely wasted but actually counter productive?

Similarly, it is critical to pay scrupulous attention to cause and effect. Throughout the war on drugs, Administration officials have been making absurd claims about the effects of anti-drug policies. Recently President Reagan asserted that the War on Drugs is working. His evidence? Marijuana smoking is down to 18 million per year and experimentation with cocaine by high schools seniors in the University of Michigan survey declined by 20%. Everyone trained in logic knows that this is the fallacy of post hoc ergo propter hoc. But one need not be trained in logic to realize that there is no provable correlation between law enforcement initiatives and levels of drug consumption. Indeed, the same University of Michigan survey shows that marijuana consumption peaked in 1979, three years before the War on Drugs even began. Cocaine is purer, cheaper and more available than ever before. If use is down, it is not because of successful law enforcement. Most categories of drug use are down and will likely continue to go down as people become more educated and more concerned about health and fitness, fueled in some immeasurable degree by media reports of celebrity overdose deaths such as David Kennedy, John Belushi, Len Bias, and Don Rogers.[75]

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[75] About the only category of drug use that appears to be up is crack, and even that may be confined in large part to urban ghettos. New York Times, July 10, 1988. The overall decline, of course, is a positive development so long as it is not offset by a corresponding rise in other drug use, e.g. alcohol or tobacco, or suicide or other forms of health-endangering behavior. In this regard, the National Commission should fund research directed toward the development of some meaningful index of health and

Another important factor is the aging of the baby boom generation. That demographic bulge leaves fewer young people behind and thus contributes to the aging of the population as a whole. An older population is simply one that is less likely to use cocaine, marijuana, and heroin.

To attribute these changes to law enforcement levels is at the least unprofessional. The liberalization of marijuana laws in California, Oregon, Maine and elsewhere in the early 1970's produced no observable rise in consumption (either new users or increased frequency) of marijuana compared to other states.[76] The connection between law and individual behavior at this level is remote. Government policies are no more responsible for the current decline in drug use than they were for the boom in the 1970's and early 1980's. Drug use will almost certainly decline in the 1990's, no matter what law enforcement does, for roughly the same reasons that cigarette smoking has declined dramatically without any change in the law.

IV. SUBSTITUTE STUDY FOR SPECULATION

The War on Drugs has produced a siege mentality. Senators from large states speak of invasions and national security threats. Even professionals who should know better succumb to anti-drug hysteria.

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well being by somehow combining total morbidity/mortality data from all major causes. It would be a true Big Picture accomplishment if we could somehow confirm that specified demographic segments were not only using drugs less but were also happier and healthier.

[76] Maloff, "A Review of the Effects of the Decriminalization of Marijuana," Contemporary Drug Problems 132 (Fall, 1981).

A former director of the National Institute of Drug Abuse claimed that without the War on Drugs to restrain the people, we would have 60-100,000,000 users of cocaine in this country.[77] Now this is extremely unlikely; because of the stimulant nature of the drug, it appeals mostly to younger people, the population is aging, there is already a downward trend in cocaine except for crack, and so forth. But rather than trading assertion and counter-assertion, the real question is epistemological: how does the Director know what he "knows." Clearly, there is no empirical basis for his claim. It must therefore be an expression of fear or perhaps political maneuver, but clearly something other than a statement of fact. Why would the Director of the public agency most responsible for informing the public on drugs take that tack? Whatever his reasons, wild speculation is not the path to informed judgment and intelligent, workable policy. Why not truly confront the question of what less restricted availability of cocaine would mean in terms of increased drug use, taking account of both prevalence and incidence.[78]

There a number of ways in which this might be done if we truly want to know the answers. One way is market research. A standard technique of market research is to conduct surveys and ask people about what they desire in a product in terms of price, quality and other features. How much will they buy at various prices? The same techniques are adaptable, mutatis mutandis, to illegal drugs.

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[77] Brinkley, "The War on Narcotics: Can It Be Won,", New York Times, Sept. 14, 1984, sec. A.

[78] To speak of a rise or fall in drug use is simplistic. It is important to distinguish between prevalence (the number of users) and incidence (the frequency of use). In measurable health consequences, it may be meaningless if the number of people who try cocaine goes up or down; conversely a change in the amounts and frequency of consumption may significantly alter morbidity and mortality.

What about the effects of the drug? Is it addictive? Longitudinal studies of the kind pioneered by Ronald Siegel of UCLA should be encouraged.[79] NIDA Household Surveys register only gross numbers and do not track users. (They do not even cover group quarters, such as college dormitories and military barracks, where drug use may be higher than average.) At the present time we have almost no real world knowledge of the experience of past and present cocaine users, except those unrepresentative few who come forward as former or recovering addicts. Even NIDA has conceded that we lack any estimate of the relative proportions of addictive use versus experimental or other non-consequential use in the total population of cocaine users.[80] Isn't that critical information in regulating the drug? (Drug users should be systematically interviewed, but they will be loathe to step forward in the current climate of repression.)

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[79] In a 1984 paper for NIDA (Research Monograph 50), Siegel concluded that the "hypothesis that long term use of cocaine is inevitably associated with an escalating dependency marked by more frequent patterns of use is not supported by the findings." Instead he found that "social recreational drug users maintained relatively stable patterns of use" in the face of ready supplies and increased income as they aged.

[80] Dr. Jerome H. Jaffe, "Foreword," Cocaine Use in America: Epidemiologic and Clinical Perspectives (NIDA, 1985). Other research agendas should include the possibility of addiction maintenance treatment and other therapeutic uses of cocaine.

Useful experiments might also be performed using volunteers from the prison population (e.g., those serving life sentences without parole) and perhaps volunteers from the military services. How would men behave and how would their health fare with abundant access to cocaine? Would it be used widely or intensively or both? Finally, comparative studies from countries such as Holland can tell us a great deal about the effects of more freely available cannabis and heroin, although not so with respect to cocaine. We have a lot to learn from the Dutch.

CONCLUSION

I endorse a substantial measure of relaxation of drug laws in some respects simultaneously with a substantial measure of intensification in other respects: the enforcement of laws to protect children, along with more stringent laws regarding the sale of liquor and tobacco. As to the first point, some measure of relaxation of drug laws is both correct in principle and pragmatically necessary in the real world of limited resources. But this is not a "surrender" in the War on Drugs. There is a paradox here, i.e., that the use of less force may actually result in producing more control over the drug situation in this country.

Consider the analogy of a panic stop in an automobile. In a typical scenario, a driver observes a sudden obstruction in his path and slams on the brakes in order to avoid a collision. If he uses too much force on the pedal, the sudden forward weight transfer will very likely induce front-wheel lockup. At that point, the car starts skidding out of control. If the driver turns the wheel left or right, the car will simply keep on skidding forward toward the very obstacle that he is trying to avoid. In this moment of panic, the "logical" or instinctive thing to do is to stomp the brake pedal even harder. But that is absolutely wrong. The correct thing to do to stop the skid is to modulate the break pedal, releasing it just enough to permit the front wheels to begin rolling again so that steering control is restored. Thus, the correct and safe response is counter-intuitive, while the instinctive response sends the driver skidding toward disaster. I leave it to the Committee to decide whether this has any relevance in the re-making of drug policy.

BIBLIOGRAPHY

The reader who wants to study U.S. drug policy in depth is advised to consult the extensive bibliography at p. 263 of Breaking the Impasse in the War on Drugs (Westport, Ct.: Greenwood Press, 1986). For convenience, reprinted below is a short introductory bibliography taken in part from a Nova Law Center Symposium "The War on Drugs: In Search of a Breakthrough," 11 Nova L.J. 891, 1050 (1987):

AN ESSENTIAL BIBLIOGRAPHY ON DRUG LAW AND POLICY

J.B. Bakalar & L. Grinspoon, Drug Control in a Free Society (Cambridge University Press 1985).

E. Brecher, Licit and Illicit Drugs: The Consumers Union Report on Narcotics, Stimulants, Depressants, Inhalants, Hallucinogens & Marijuana - Including Caffeine, Nicotine and Alcohol (Consumers Union 1973).

R. Byck, ed., Cocaine Papers: Sigmund Freud (New American Library (1974).

J. Grabowski (ed.), Cocaine: Pharmacology, Effects, and Treatment of Abuse (National Institute on Drug Abuse Research Monograph 50, 1984).

L. Grinspoon & J.B. Bakalar, Cocaine: A Drug and Its Social Evaluation ((Basic Books rev. ed. 1985).

L. Grinspoon, Marihuana Reconsidered (Harvard University Press 1971) (Bantam Books 1971) (2d ed. 1977).

Institute of Medicine, Division of Public Sciences Study, Marijuana and Health (National Academy Press 1982).

Institute of Medicine, Division of Health Promotion and Disease Prevention, Alcoholism, Alcohol Abuse, and Related Problems: Opportunities for Research (National Academy Press 1980).

J. Kaplan, Marijuana - The New Prohibition (World Pub. Co. 1970).

J. Kaplan, The Hardest Drug: Heroin and Public Policy (University of Chicago Press 1983).

N.J. Kozel & E. H. Adams, eds., Cocaine Use in America: Epidemiology and Clinical Perspectives (National Institute on Drug Abuse Monograph 61, 1985).

D. Lee, Cocaine Handbook: An Essential Reference (And/Or Press 1980).

Liaison Task Panel on Psychoactive Drug Use/Misuse, Task Panel Reports Submitted to the President's Commission on Mental Health (vol. IV, Appendix 2103-40) (U.S. Gov't Printing Office 1978).

M. Moore, Buy and Bust: The Effective Regulation of an Illicit Market in Heroin (Lexington Books 1977).

D.F. Musto, M.D., The American Disease: Origins of Narcotic Control (Yale University Press 1973).

National Commission on Marihuana and Drug Abuse, Marihuana: A Signal of Misunderstanding (U.S. Gov't Printing Office 1972).

National Drug Enforcement Policy Board, Federal Drug Enforcement Progress Report, 1985-86 (U.S. Gov't Printing Office 1986).

H. Packer, The Limits of the Criminal Sanction (Stanford University Press 1968).

J. Phillips & R. Wynne, Cocaine: The Mystique and the Reality (Avon Books 1980).

President's Commission on Organized Crime, America's Habit: Drug Abuse, Drug Trafficking, and Organized Crime (U.S. Gov't Printing Office 1986).

T. Szasz, Ceremonial Chemistry: The Ritual Persecution of Drugs, Addicts, and Pushers (Doubleday Anchor 1976).

A. Trebach, The Heroin Solution (Yale University Press 1982).

A. Weil, M.D., The Natural Mind: A New Way of Looking at Drugs and the Higher Consciousness (Houghton Mifflin Co. 1972).

S. Wisotsky, Breaking the Impasse in the War on Drugs (Greenwood Press 1986).

S. Wisotsky, Exposing the War on Cocaine: The Futility and Destructiveness of Prohibition, 1983 Wis. L. Rev. 1305.

S. Wisotsky, Crackdown: The Emerging "Drug Exception" to the Bill of Rights, 38 Hastings L. J. 889 (1987).

S. Wisotsky, The Ideology of Drug Testing, 11 Nova L.J. 763 (1987).

N.E. Zinberg, Drug, Set and Setting: The Basis for Controlled Intoxicant Use (Yale University Press 1984).

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U.S. DRUG POLICY: A BAD EXPORT

by Ethan A. Nadelmann

Almost everyone seems to agree that the "drug problem" is now a major international issue. U.S. relations with several Latin American countries are seriously strained because of these countries' inability to control the drug trade. Political leaders across the spectrum are advocating U.S. military involvement in suppression efforts; U.S. troops have even been deployed abroad in an effort to disrupt the production and export of cocaine from Bolivia.

At home political figures endorse increasingly repressive measures to try to stamp out drug use. There are calls for more widespread drug testing, increasingly powerful investigative tools for drug enforcement agencies, and greater expenditures on all aspects of drug enforcement.

The political tide is now so strong that drug policy, perhaps more than any other domain of public policy, has been captured by its own rhetoric and effectively immunized from critical examination. Clearly the time has come for a more rational discussion of the drug problem—one that attempts to distinguish the problems of drug abuse, on the one hand, from the problems that result from drug prohibition policies, on the other.

Obsessed with the need to control drug trafficking, governments have enacted and enforced increasingly harsh criminal penalties regulating virtually every aspect of drug use with little regard for the costs imposed by these laws. These costs can be measured not just in tax dollars, but also in individual lives, personal liberties, political stability, social welfare, and moral well-being. Federal and state governments spend several billion dollars each year to enforce the increasingly repressive laws inside the United States. And U.S. diplomats press governments around the world to follow the American lead and enact their own harsh measures against drug use and traf-

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ficking. Meanwhile, there is no indication that the magnitude of the worldwide drug abuse problem is declining. Indeed, there is good reason to believe that the current American approach actually may be exacerbating most aspects of what is commonly identified as the drug problem.

Sixty years ago, most Americans demonstrated a clear ability to distinguish between the problems of alcoholism and alcohol abuse and the costs imposed by the prohibition laws. The debate between proponents and opponents of Prohibition ultimately revolved around conflicting interpretations of what both sides regarded as a cost-benefit analysis. Unfortunately, today few Americans demonstrate any aptitude for distinguishing between the problems of drug abuse and those occasioned by the drug prohibition laws. Yet so much of what Americans typically identify as part and parcel of the drug problem falls within the latter, not the former, category.

No doubt most people resist thinking about the drug problem in terms of the Prohibition analogy because the notion of repealing the current drug laws is not regarded as a viable policy option. Indeed, the very suggestion of such a possibility quickly conjures up images of an America transformed into a modern-day Sodom and Gomorrah. Yet there are powerful reasons to at least attempt a reasoned analysis of the costs and benefits of current drug policies. First, an optimal drug policy must aim to minimize not just drug abuse but also the costs to society imposed by drug control measures. Second, there are numerous alternatives to current policies, among which the libertarian vision of unrestricted access to all drugs is only one and certainly the most radical. Third, there is good reason to believe that repealing many of the current drug laws would not lead to a dramatic rise in drug abuse, especially if intelligent alternative measures were implemented.

All public policies create beneficiaries and victims, both intended and unintended. When a policy results in a disproportionate magnitude of unintended victims, there is good reason to reevaluate its assumptions. In the case of drug prohibition policies, the intended beneficiaries are those individuals who would become drug abusers but for the existence and enforcement of the drug laws. The intended victims are those who traffic in illicit drugs and suffer the legal consequences. The unintended beneficiaries, conversely, are the drug producers and traffickers who profit handsomely from the illegality of the market while avoiding arrest by the authorities and violence by other criminals. Each of these three categories is readily recognizable. The unintended victims of drug prohibition policies, however, are rarely recognized as such. Indeed, they are most typically portrayed as the victims of the unintended beneficiaries—that is, the drug traffickers—when in fact the drug prohibition policies are the principal cause of their victimization.

In certain respects, the Latin American countries are among the principal unintended beneficiaries of U.S. drug policies. The international demand for illegal drugs such as marijuana and cocaine has proved to be an economic boon for Latin America. This has been especially true for the main source countries—Bolivia, Colombia, and Peru. Much, but by no means all, of the economic benefit has derived from the market's illegality. Government repression of the market has had the same effect as a huge tax except that the revenue is collected not by governments but by illicit sellers. Hundreds of thousands of farm families, primarily in Bolivia, Colombia, and Peru, have earned far more from growing coca, the agricultural raw material for cocaine, than they would have from growing any other crop. The same is true of tens of thousands of marijuana growers in Belize, Colombia, Jamaica, and Mexico. Others involved in refining, transporting, or protecting the illegal product have supplemented or replaced meager incomes earned in the legitimate economy. Countless corrupt officials likewise have pocketed money from the illicit trade. In addition to these groups that benefit directly, significant sectors of the population in several Latin American countries have benefited indirectly from the trickle-down effects of the trade.

Because the market is illicit, it is impossible to offer any but the most speculative estimates of its total value to Latin Americans. The Bolivian government has estimated that the cocaine trade brings about $600 million per year into its economy, a figure equal to the country's total legal export income. Peru, which produces about the same amount of cocaine, probably earns a similar amount although it accounts for a lesser proportion of its total exports. In both these countries, a large proportion of the coca money is distributed among the growers and other low-level participants in the market. In Colombia, there are fewer growers but more people involved in support areas of the business such as transport and security. All told, cocaine and marijuana exports probably generate a minimum of $2 billion a year in foreign currency for Latin Americans—excluding the additional billions invested outside the continent.

An optimal drug policy must aim to minimize not just drug abuse but also the costs to society imposed by drug control measures.

If it is fair to say that some Latin Americans are the unintended economic beneficiaries of U.S. and international drug prohibition policies, it is equally valid to identify others as the unintended political and social victims of those policies. The recent dramatic increases in cocaine smoking among the youth of Bolivia, Colombia, and Peru are one consequence. Even more ominous, the drug market's huge size, combined with its illegality, has generated tremendous corruption, lawlessness, and violence throughout Latin America. It is not that these evils did not exist before the boom in drug trafficking, but that they have mushroomed in scope and magnitude. Government officials ranging from common police officers to judges to cabinet ministers have been offered bribes many times their annual government salaries, and often for doing nothing more than looking the other way. Inducing cooperation has been the threat of violence if the bribes are not accepted. In addition, the limits on what can be bought with corruption have evaporated. Supreme court judges, high-ranking police and military officials, and cabinet ministers are no longer above such things.

The ultimate degree of corruption is when government officials take the initiative in perpetrating crimes. This also has happened throughout much of Latin America. Police officers no longer just accept bribes or extort from traffickers but engage in trafficking themselves. Provincial mayors and governors enter into partnerships with full-time drug traffickers. And even military officers, who in at least a few countries traditionally have shunned drug corruption, have succumbed to the temptation of cocaine dollars. This has occurred not just in the major drug-producing countries but throughout the continent as well. No country, from Cuba to Chile, seems to be immune.

Perhaps even worse than the corruption of governments has been the growth in the power of criminal groups. The two cannot be disentangled from one another, of course, but they are distinct. In many Latin American countries drug-trafficking organizations, rather than the government, now represent the ultimate power in portions of a country if not the country as a whole. Government officials who oppose this extralegal power know that ultimately the government cannot protect them or their families. In the United States, only one federal judge has been killed in a hundred years, and it is almost unheard of for a federal prosecutor to be killed. Even police rarely need to fear the vengeance of those they arrest. In Latin America, however, not just police but also prosecutors and judges have been killed by the dozens. In Colombia, drug traffickers have killed a minister of justice, a Supreme Court justice, an attorney general, and a chief of the narcotics police. In the final analysis, the monumental scope of the illicit drug traffic, created largely by U.S. demand and the illegality of the market, has eroded the ultimate authority of the state as a symbol and enforcer of law and order in many Latin American countries.

What can Latin American countries do? From their perspective, the most sensible solution to drug-related corruption and criminal activity would be international legalization of the marijuana and cocaine markets. Their drug problems, after all, stem almost entirely from the illegality of the market. If it were legal, it would function not unlike the international markets in legal substances such as liquor, coffee, and tobacco. It would be regulated to varying degrees by the governments of both producing and consuming countries; the individual and corporate participants in the market would pay taxes and duties; consumers would have available more accurate information on the products themselves; and the governments would spare themselves the exorbitant costs of trying to enforce the drug prohibition laws. No doubt companies already specializing in the production and marketing of alcohol, coffee, and tobacco would play a major role in this business as well. There probably would be some market adjustment. For example, foreign suppliers, especially of marijuana, might yield a sizable share of their market to new suppliers within the United States. And there undoubtedly would also be a certain amount of smuggling, largely to avoid duties and other customs regulations. But its incentives and scale probably would be most similar to those that attend the legal substance markets today.

The social and political benefits would be critical. Levels of corruption, violence, and lawlessness would decline dramatically. Latin American governments no longer would be placed in the awkward situation of trying to destroy the livelihoods of hundreds of thousands of campesinos. Radical guerrilla groups such as Peru's Sendero Luminoso (Shining Path), which have gained political support from their attacks on U.S.-sponsored antidrug programs, would lose some of their appeal. Other guerrilla and terrorist groups, such as Colombia's FARC (Colombian Revolutionary Armed Forces) and M-19, which have profited from their involvement in the illicit drug trade, would lose a major source of funding. And governments would be able to reassert some degree of control over regions of their countries that are now dominated by powerful *narcotraficantes*.

Today many drug specialists, including Drug Enforcement Administration chief John Lawn, concede that stopping the flow of drugs is impossible. They know that whenever drug control efforts succeed in cracking down on one source country or disrupting one major trafficking route, another soon emerges in its place. International drug enforcement efforts are thus justified on the grounds that they are essential in limiting consumption by keeping the retail street price of the substances as high as possible. But the price is, in fact, influenced little, if at all, by changes in drug enforcement efforts in the supplying countries. In 1987, for instance, average-grade marijuana reportedly was selling for $6–$11 per pound at Colombian beaches and airstrips. On arrival in the United States, its worth increased approximately ninetyfold, to $550–$990 per pound. With respect to cocaine, the markup from Colombian airstrip to Miami wholesaler was only fivefold, from $3,600–$4,400 to $17,000–$22,000 per kilo. But unlike marijuana, which increases only three or four times in value from wholesale to retail, the ultimate value of a kilo of cocaine is $80,000–$120,000, for as much as a sevenfold markup.

Although the tremendous range in drug prices renders precise calculations impossible, estimated average prices indicate that the foreign price of marijuana is only slightly more than 1 per cent of its U.S. wholesale price and .5 per cent of the retail price paid by the U.S. consumer. The foreign price of cocaine is 20 per cent of the U.S. wholesale price but only about 4 per cent of the ultimate retail price. Consequently, even if substantial enforcement efforts were to quadruple or quintuple the foreign prices of these substances, there would be almost no price effect on the American consumer—and only in the case of cocaine would wholesalers be much affected. With respect to heroin, the irrelevance of source control efforts to the retail street price in the United States is even greater.

Limitations on the ultimate success of the international regime to control drug trafficking are best comprehended by comparing the drug regime with other international law enforcement regimes. In certain important respects the drug regime resembles other international law enforcement regimes, such as those that nearly eradicated piracy and slavery during the previous century or those established more recently that deal with counterfeit currency and airplane hijacking. In each case, the vast majority of governments ultimately recognized a mutual interest in not participating, directly or indirectly, in such illegal acts and in cooperating in their suppression. Moreover, each act has come to be regarded in international law as in some sense an international crime.

However, the drug regime differs from other international law enforcement regimes in at least two significant respects. First, despite rhetoric to the contrary, it lacks a deeply rooted moral consensus that the activity in question is wrong. Second, crimes that require limited resources and no particular expertise to commit, that are easily concealable, and that create no victims with an interest in notifying authorities are most likely to resist enforcement efforts. Each of these characteristics describes drug trafficking. For instance, unlike counterfeiting, no particular expertise is required to become a drug smuggler. Even in the United States, marijuana is grown profitably by tens of thousands of people with no more training than can be acquired in a local library. In the less developed countries where opium poppies, coca, and cannabis for foreign markets are grown and refined, hundreds of thousands of poorly educated farmers participate in the market. Nor does it require any special expertise to be a drug courier. The potential number of successful counterfeiters is an extremely small number; the potential number of successful drug traffickers is virtually infinite.

Most aspects of drug trafficking are easily concealable. The crops are often grown in inaccessible hinterlands and camouflaged with legitimate crops. Their transport to the United States is also exceedingly difficult to detect. The approximately 100 tons of cocaine exported from Latin America during each of the past few years constitute a small percentage of the total volume of exports. The private aircraft in which large shipments are typically transported are exceedingly difficult to interdict. There also are tremendous economic incentives to smuggle even very small amounts. An average profit for smuggling just 1, easily concealed, kilo of cocaine, after all, is $15,000. With temptation such as this, there is almost no limit to the number of individuals willing to transport 1 or 2 kilos on commercial aircraft.

Although the international slave trade, like the drug traffic, was driven by the prospect of higher profits than could be attained in legitimate commerce, it was a far more visible trade. Ships carrying slaves from Africa usually could be identified far more readily than the vessels that transport marijuana and cocaine today. Even more important, the purchasers of slaves had much more difficulty concealing their illegal "property" than do the ultimate customers of illicit drugs.

Finally, the victims of slavery, piracy, counterfeiting, and hijacking are eager to have others know of their plight. But the willing "victims" of the drug trade have no intention of notifying the authorities. Drug trafficking, which involves willing buyers and sellers, unlike the other targets of international law enforcement regimes, is an entirely consensual activity.

It can be argued, of course, that drug trafficking also creates its own victims—in particular those who become dependent upon the drugs and, less directly, those who suffer as a consequence of others' abuse of drugs. The great difference, however, is that the immediate victims of drug trafficking, unlike the victims of other international crimes, are self-chosen in that their initial steps on the road to victimization are consensual ones.

In the case of each successful international law enforcement regime, the activity could not be effectively suppressed until a broad consensus had developed across diverse societies that viewed the activity as morally noxious. Such a consensus in regard to the immorality of piracy developed throughout much of the world during the 18th century. A similar consensus evolved with respect to slavery during the 19th century. The reason these and subsequent consensuses underlying other international law enforcement regimes evolved was essentially the same: the activity itself directly victimized innocents. The basic problem of the antidrug regime, and for that matter of the efforts in the early part of this century to create antialcohol and antiprostitution regimes, has been the absence of just such a consensus. For all the undeniable victims of these vices, many others involved in the activities were not, and did not perceive themselves as, victims. Thus despite the efforts of the United States and some other governments to create the veneer of an international moral consensus on the drug issue, a true consensus does not exist—and will not be attained—either within the United States or around the world.

Comparing Risks

The case for legalization is particularly convincing when the risks inherent in alcohol and tobacco use are compared with those associated with illicit drug use. Both in Latin America and in the United States, the health costs exacted by illicit drug use pale in comparison with those associated with tobacco and alcohol use. In September 1986, the Department of Health and Human Services reported that in the United States, alcohol was a contributing factor in 10 per cent of work-related injuries, 40 per cent of suicide attempts, and also 40 per cent of the approximately 46,000 traffic deaths in 1983. That same year the total cost of alcohol abuse to American society was estimated at more than $100 billion. An estimated 18 million Americans are currently reported to be either alcoholics or alcohol abusers. Alcohol has been identified as the direct cause of 80,000 to 100,000 deaths annually and as a contributing factor in an additional 100,000 deaths.[1] The health costs of tobacco use in the United States and elsewhere are different but of similar magnitude. In the United States alone in 1984, more than 320,000 deaths were attributed to tobacco consumption. All of the health costs of marijuana, cocaine, and heroin combined amount to only a fraction of those of either of the two licit substances.

According to the National Council on Alcoholism, only 3,562 people were known to have died in 1985 from use of all illegal drugs combined. Logic would dictate that, if any substances warrant criminal sanction for health reasons, they are alcohol and tobacco, which are used by 140,000,000 and 50,000,000 people respectively. However, most people seem to believe that there is something fundamentally different about alcohol and tobacco that legitimates the legal distinction between those two substances and the illicit ones. The most common distinction is based on the assumption that the illicit drugs are more dangerous than the licit ones. Cocaine, heroin, the various hallucinogens, and, to a lesser extent, marijuana, are widely perceived as, in the words of the President's Commission on Organized Crime, "inherently destructive to mind and body." They are also believed to be more addictive and more likely to cause dangerous and violent behavior than are alcohol and tobacco. All use of illicit drugs is typically equated with drug abuse. In short, the distinction between use and abuse of psychoactive substances that most people recognize with respect to alcohol is not regarded as relevant in the case of illicit substances.

Many Americans also make the fallacious assumption that the government would not criminalize certain psychoactive substances if they were not in fact dangerous. They then jump to the conclusion that any use of those substances is a form of abuse. The government, in its efforts to discourage people from using illicit drugs, has encouraged and perpetuated these misconceptions not just in its rhetoric but also in its purportedly educational materials. Only by reading between the lines can the fact be discerned that the vast majority of Americans who have used illicit drugs have done so in moderation, that relatively few have suffered negative short-term consequences, and given available evidence, that few are likely to suffer long-term harm.

The evidence is most persuasive with respect to marijuana. The National Narcotics Intelligence Consumers Committee, an interagency body that coordinates drug-related intelligence, did not include marijuana-related deaths in its June 1987 report, apparently because so few occur. Nor is marijuana strongly identified as a dependence-causing substance. The dangers associated with cocaine, heroin, and hallucinogens certainly are greater, but not nearly as great as most people seem to think. Consider the case of cocaine. In 1986 the National Institute on Drug Abuse (NIDA) reported that more than 20 million Americans had tried cocaine in 1985, that 12.2 million had consumed it at least once during that year, and that nearly 5.8 million had used it within the past month. It should be noted that the NIDA survey did not include persons residing in military or student dormitories, prison inmates, or the homeless.

Although a figure for weekly cocaine consumption among the entire survey population is unavailable, NIDA has compiled such information with regard to 18–25-year-olds: 250,000 had used it on the average weekly; 2.5 million had used it within the past month; 5.3 million had used it within the past year; and 8.2 million Americans in this age group had ever used cocaine. It could be inferred from these figures that a quarter of a million young Americans were potential problem users. It could also be determined that only 3 per cent of those 18–25-year-olds who had ever tried the drug fell into that category, and that only 10 per cent of those who had used cocaine monthly were at risk.

All of this is not to say that cocaine is not a potentially dangerous drug, especially when it is injected or smoked in the form of "crack." But there is also evidence that most cocaine users do not get into trouble with the drug. So much of the media attention has focused on the small percentage of cocaine users who become addicted that the popular perception of how most people use cocaine has become badly distorted. In one survey of high school seniors' drug use, the researchers questioned those who had used cocaine recently as to whether they had ever tried to stop using cocaine and found that they could not. Only 3.8 per cent responded affirmatively, in contrast with the almost 7 per cent of marijuana smokers who said they had tried to stop and found they could not and the 18 per cent of cigarette smokers who answered similarly.[2] Although a survey of adult users probably would reveal a higher proportion of cocaine addicts, evidence such as this suggests that only a small percentage of people who use cocaine end up having a problem with it. In this respect, most Americans differ from monkeys, who have demonstrated in tests that they will starve themselves to death if provided with unlimited cocaine.

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[1] *Tom Wicker, "Drugs and Alcohol,"* New York Times, *13 May 1987, A27.*

In many Latin American countries drug-trafficking organizations, rather than the government, now represent the ultimate power in portions of a country if not the country as a whole.

With respect to the hallucinogens such as LSD and psilocybin, their potential for addiction is virtually nil. The dangers arise primarily from using them irresponsibly on individual occasions.[3] Although many of those who have used one or another of the hallucinogens have experienced "bad trips," far more have reported positive experiences and very few have suffered any long-term harm.

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[2] *Patrick M. O'Malley, Lloyd D. Johnston, and Jerald G. Bachman, "Cocaine Use among American Adolescents and Young Adults," in* Cocaine Use in America: Epidemiological and Clinical Perspectives, *ed. Nicholas J. Kozel and Edgar H. Adams, National Institute of Drug Abuse Research Monograph 61 (Washington, D.C., GPO, 1985), 73.*

[3] *Lester Grinspoon and James B. Bakalar,* Psychedelic Drugs Reconsidered *(New York: Basic Books, 1979), 157–191.*

Perhaps no drugs are regarded with as much horror as the opiates, and in particular heroin, which is a more concentrated form of morphine. There is no question that heroin is potentially highly addictive. But despite the popular association of heroin use with the most down-and-out inhabitants of urban ghettos, heroin causes relatively little physical harm to the human body and certainly far less than alcohol and tobacco.[4] That is one reason many American doctors in the 19th and early 20th centuries saw opiate addiction as preferable to alcoholism and prescribed the former as treatment for the latter when abstinence did not seem a realistic option.[5] It is both insightful and important to think about the illicit drugs in the same way as alcohol and tobacco. Like tobacco, many of the illicit substances are highly addictive, but many people can consume them on a regular basis for decades without any demonstrable harm. Like alcohol, most of the substances can be, and are, used by most consumers in moderation with little in the way of harmful effects; but like alcohol they also lend themselves to abuse by a minority of users who become addicted or otherwise harm themselves or others as a consequence. And like both the legal substances, the psychoactive effects of each of the illegal drugs vary greatly from one person to another. To be sure, the pharmacology of the substance is important, as is its purity and the manner in which it is consumed. But much also depends upon not just the physiology and psychology of the consumers but their expectations of the drug, their social milieu, and the broader cultural environment—what the Harvard University psychiatrist Norman Zinberg has called the "set and setting" of the drug.[6] These factors might change dramatically, albeit in indeterminate ways, were the illicit drugs made legally available.

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[4] *John Kaplan,* The Hardest Drug: Heroin and Public Policy *(Chicago: University of Chicago Press, 1983), 127.*

[5] *Consumer Reports Book Editors and Edward M. Brecher,* Licit and Illicit Drugs: The Consumers Union Report on Narcotics, Stimulants, Depressants, Inhalants, Hallucinogens, and Marijuana—including Caffeine, Nicotine, and Alcohol *(Boston: Little, Brown, 1972), 8–9.*

[6] *See Norman Zinberg,* Drug, Set, and Setting: The Basis for Controlled Intoxicant Use *(New Haven, Conn.: Yale University Press, 1984).*

Clearly, then, there is no valid basis for distinguishing between alcohol and tobacco, on the one hand, and most of the illicit substances, on the other, as far as their relative dangers are concerned. However, even many of those who acknowledge this fact insist that there is another distinction, a moral one, that justifies the different legal treatments of the various drugs. But when this distinction is subjected to reasoned analysis, it also quickly disintegrates. Once the fact that there is nothing immoral about drinking alcohol or smoking tobacco for nonmedicinal reasons is acknowledged, it becomes difficult to condemn on moral grounds consumption of marijuana, cocaine, and other substances. The "moral" condemnation of some substances and not others is revealed as little more than a prejudice in favor of some drugs and against others. It could be argued, of course, that morality is really nothing more than the prejudices of the majority. But to the extent that it is defined as something more than that, there can be no legitimate reason for distinguishing on moral grounds between alcohol and tobacco use and the use of illicit substances.

The same false distinction is drawn even more severely when it comes to those who provide the psychoactive substances to users and abusers alike. If degrees of immorality were measured by the levels of harm caused by a dealer's products, the "traffickers" in tobacco and alcohol would be vilified as the most evil of all substance purveyors. That they are perceived instead as respectable, even important, members of the community while providers of the no more dangerous illicit substances are punished with long prison sentences says much about the prejudices of most Americans with respect to psychoactive substances but little about the morality or immorality of their activities.

Although a direct moral distinction cannot be drawn between the licit and the illicit psychoactive substances, it is possible to point to a different kind of moral justification for the drug laws. Those laws can be viewed as embodying a paternalistic obligation to protect those who cannot protect themselves from succumbing to their own weaknesses. If the illegal drugs were legally available, most people would either abstain from using them or else use them responsibly and in moderation. A small minority who lacked sufficient self-restraint, however, would end up harming themselves if the substances were more readily available. Therefore, it is argued, the majority has a moral obligation to deny its members legal access to certain substances because of the foibles of the minority. This obligation presumably applies most strongly when children are included among the minority.

This argument, at least in principle, seems to provide the strongest moral justification for the drug laws. But ultimately the moral quality of laws must be judged not by how those laws are intended to work in principle but by how they function in fact. When laws intended to reflect a moral obligation cause new harms of a different kind, arguably even greater in impact, there is a need to re-evaluate them and inquire whether those laws have become in some sense immoral.

Drug-Policy Alternatives

There are those who acknowledge the greater harms caused by alcohol and tobacco but who justify the criminalization of other substances on the ground that two wrongs do not make a third wrong right. The logic of their argument, however, ultimately crumbles when the costs of the drug laws are considered. There is little question that if the production, sale, and possession of alcohol and tobacco were criminalized, the health costs associated with their use and abuse could be reduced. But most Americans do not believe that criminalizing the alcohol and tobacco markets would be a good idea. Their opposition stems largely from two beliefs: that adult Americans have the right to choose what substances they will consume and what risks they will take, and that the economic costs of trying to coerce so many Americans into abstaining from those substances would be enormous and the social costs disastrous.

An assessment of the costs and benefits of current drug control policies in the United States requires some sense of what the alternatives would be. When Prohibition's proponents and opponents debated the merits of the 18th Amendment, they were able to draw on their recent memories. The difficulty in contemplating the alternatives to drug prohibition is that few people can remember when heroin, cocaine, and even marijuana were legally available. The first federal legislation severely restricting the sale of cocaine and the opiates was the 1914 Harrison Act. Marijuana did not become the subject of federal legislation until 1937, when Congress passed the Marijuana Tax Act. In both cases, however, state legislatures around the country already had imposed their own restrictions on the availability of these drugs, motivated in good part by the popular association of these substances with feared minorities—the opiates with the Chinese immigrants; cocaine with blacks; and marijuana with blacks and Hispanics. Even so, the late 19th century and the first years of the 20th century could be described as a period in which most of today's illicit drugs were more or less legally available to those who wanted them. The United States at that time had a drug abuse problem of roughly similar magnitude to today's problem, but it was perceived almost entirely as a public and private health issue. Crime and law enforcement played little role in the nature, perception, and handling of the problem.

In 1987 direct expenditures on drug interdiction incurred by the military, which markedly underestimate actual costs, increased significantly from almost nothing in 1981 to about $165 million. Expenditures in this area by the three principal intelligence agencies—the CIA, the Defense Intelligence Agency, and the National Security Agency—also have increased dramatically. The Drug Enforcement Administration's budget has risen from about $200 million in 1980 to a projected $500 million in 1988, and almost all of the other federal law enforcement agencies—in particular, the FBI and the U.S. Customs Service—have increased dramatically the proportion of their resources devoted to drug enforcement activities. In an August 1987 study prepared for the U.S. Customs Service by Wharton Econometrics, state and local police were estimated to have devoted about one-fifth of their total budgets, or close to $5 billion, to drug-law enforcement in 1986. This represented a 19 per cent increase over the previous year's expenditures. All told, 1987 expenditures on all aspects of drug enforcement, from drug eradication in foreign countries to imprisonment of drug users and dealers in the United States, probably totaled at least $8 billion.

Even more significant than the actual expenditures has been the diversion of limited resources—including experienced and talented judges and prosecutors and law enforcement agents, as well as scarce prison space—from enforcement against criminal activities that harm far more innocent victims than do violators of the drug laws. Drug-law violators account for approximately one-tenth of the roughly 800,000 inmates in state prisons and local jails and more than one-third of the 44,000 federal prison inmates, according to U.S. Department of Justice statistics. These proportions are expected to increase in coming years even as total prison populations continue to rise dramatically. Largely as a consequence of the Anti-Drug Abuse Act passed by Congress in 1986, the proportion of federal inmates incarcerated for drug violations is expected to rise from one-third of the 44,000 prisoners currently sentenced to federal prisons to one-half of the 100,000–150,000 federal prisoners anticipated in 15 years. The direct cost of building and maintaining enough state and federal prisons to house this growing population is rising at an astronomical rate. The opportunity costs in terms of alternative social expenditures forgone and other types of criminals not imprisoned are perhaps even more severe.

FBI figures show that during each of the last few years, about 750,000 people were arrested on drug charges. Slightly more than three-fourths of these arrests were not for manufacturing or dealing drugs but solely for possessing an illicit drug, typically marijuana. (Those arrested, it is worth noting, represented less than 3 per cent of the 30 million Americans estimated to have consumed an illegal drug during the past year.) Criminal justice systems in many cities are clogged. In New York City, 41 per cent of all felony indictments during the first 3 months of 1987 were for drug offenses.[7]

Other costs are equally great but somewhat harder to evaluate: the governmental corruption that inevitably attends enforcement of the drug laws; the effects of labeling the tens of millions who use drugs illicitly as criminals, subjecting them to the risks of criminal sanction and obliging many of those same people to enter into relationships with drug dealers—who may be criminals in many more senses of the word—to purchase their drugs; the cynicism that such laws generate toward other laws and the law in general; and the sense of hostility and suspicion that many otherwise law-abiding individuals feel toward law enforcement officials. It was costs like these that strongly influenced many of Prohibition's more conservative opponents. As John D. Rockefeller, Jr., wrote in explaining why he was withdrawing as a leading supporter of Prohibition and calling for its repeal:

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[7] New York Times, *7 June 1987, 39.*

> That a vast array of lawbreakers has been recruited and financed on a colossal scale; that many of our best citizens, piqued at what they regarded as an infringement of their private rights, have openly and unabashedly disregarded the Eighteenth Amendment; that as an inevitable result respect for all law has been greatly lessened; that crime has increased to an unprecedented degree—I have slowly and reluctantly come to believe.

The unintended beneficiaries of the drug laws, as in Latin America, have been the organized and unorganized criminals who thwart the law to their great profit. A report issued by the President's Commission on Organized Crime identified the sale of illicit drugs as the leading source of revenue for organized crime in 1986, with the marijuana and heroin business each providing more than $7 billion and the cocaine business more than $13 billion. By contrast, revenues from cigarette bootlegging were estimated at $290,000,000. If the marijuana, cocaine, and heroin markets were legal, state and federal governments would collect billions of dollars annually in tax revenues. Instead they expend billions.

During Prohibition, violent struggles between bootlegging gangs and hijackings of liquor-laden trucks and sea vessels were frequent and notorious occurrences. Today's equivalents are the booby traps that surround some marijuana fields, the Caribbean pirates looking to plunder drug-laden vessels en route to U.S. shores, and the machine-gun battles and executions of the more sordid drug mafias—all of which occasionally kill innocent people. Most law enforcement authorities agree that the dramatic increases in urban murder rates during the past few years can be explained almost entirely by the rise in drug-dealer killings, mainly of one another.

Perhaps the most unfortunate victims of the drug prohibition policies have been the law-abiding residents of America's ghettos. These policies account for much of what ghetto residents identify as the drug problem. In many neighborhoods, it often seems to be the aggressive, gun-toting drug dealers who upset residents far more than the addicts nodding in doorways. As in Medellín, Colombia, and Rio de Janeiro, Brazil, the drug dealers are widely perceived as heroes and successful role models. In impoverished neighborhoods, they often stand out as symbols of success to children who see no other options. At the same time, the increasingly harsh criminal penalties imposed on adult drug dealers have led to the widespread recruitment of juveniles by drug traffickers. Where once children started dealing drugs only after they had been using them for a few years, today the sequence is often reversed. Many children start to use illegal drugs now only after they have worked for older drug dealers for a while. And the juvenile justice system offers no realistic options for dealing with this growing problem.

Despite the efforts of the United States and some other governments to create the veneer of an international moral consensus on the drug issue, a true consensus does not exist—and will not be attained—either within the United States or around the world.

Among the most difficult costs to evaluate are those created by the high price of most illicit drugs, notably cocaine and heroin. Whereas drug laws and their enforcement seek to make the drugs so prohibitive in price that people cannot or will not pay for them, there are vast costs involved in making drugs so expensive. In particular, many of those who desire or become addicted to the illicit substances not only divert substantial portions of their incomes to drug purchases but often end up committing crimes to fund their drug needs. Unlike the millions of alcoholics who can support their habits for relatively modest amounts, many cocaine and heroin addicts are reported to spend hundreds and even thousands of dollars per week. If those drugs were dramatically cheaper, which would be the case either if they were legalized or if the drug laws were no longer enforced, the number of crimes committed by drug addicts to pay for their habits would obviously decline dramatically. So would the profits, power, and incentives of the drug traffickers.

The drug prohibition laws pose additional problems for the millions of drug users who have not been deterred from using illicit drugs in the first place. Nothing resembling an underground Food and Drug Administration has arisen to impose quality control on the illegal drug market. Many marijuana smokers are worse off for having smoked cannabis that was grown with dangerous fertilizers, sprayed with the herbicide paraquat, or mixed with more dangerous substances. Consumers of heroin and the various synthetic substances sold on the street face even severer consequences, including fatal overdoses and poisonings from unexpectedly potent or impure drug supplies. Many advocates of current policies argue, probably correctly, that the unreliable quality of illicit drugs serves as an important deterrent to more widespread use. The question that few ask, however, is whether the costs of that deterrent factor outweigh the benefits.

In fact, intravenous drug users accounted for more than 50 per cent of all deaths related to acquired immune deficiency syndrome (AIDS) in New York City from 1981 to 1986. Reports have emerged that drug dealers are beginning to provide clean needles along with their illegal drugs. But even as other local governments around the world actively attempt to limit the spread of AIDS by and among drug users by making treatment programs more readily available and instituting free needle-exchange programs, state and municipal governments in the United States resist following suit. Only in January 1988 did New York City approve such a program on a very limited and experimental basis. The thought cannot help coming to mind that government policy in this area is motivated in part by the unspoken assumption that AIDS will resolve the heroin problem in a way the criminal justice system never can.

Another cost of current drug prohibition policies, caused largely by the government's enthusiasm for demonizing the drugs that are illegal, are

the restrictions on using the illicit drugs for legitimate medical purposes. For example, marijuana has been found to be useful in treating glaucoma and as an anticonvulsant for some victims of cerebral palsy and multiple sclerosis, and it is particularly effective in reducing the nausea that accompanies chemotherapy. And research indicates that psychedelic drugs, such as LSD, peyote, and MDMA (known as Ecstasy), may be helpful in psychotherapy and in reducing tension, depression, pain, and fear of death in the terminally ill. Similarly, heroin has proved more effective than other painkillers in helping some patients deal with acute pain. But current drug prohibition laws make it difficult, if not impossible, for doctors to prescribe these drugs, and they severely hamper the efforts of researchers to investigate these and other potential medical uses of the illegal drugs.

Perhaps the most intangible costs of the drug prohibition policies stem from the ways in which they are enforced. Because violations of the drug laws involve consensual activities and create no victims with an interest in reporting the crime to the police, law enforcement authorities are particularly dependent upon the most invasive and noxious investigative techniques to detect criminal violations. Drug enforcement agents rely heavily on informants drawn from the criminal milieu, on undercover operations, and on electronic surveillance. These techniques are certainly indispensable to effective law enforcement, but they are also among the least desirable of the tools available to police. And there are good reasons for requiring that they be used sparingly. Certainly a country committed to many of the values reflected in the U.S. Constitution should find it hard to admire the notion of police spying on citizens and paying others to do the same.

Voices for Legalization

Despite the soaring costs—economic, political, and social—associated with drug prohibition policies, little popular support can be found for repealing the drug laws. The percentage of Americans supporting legalization even of marijuana has dropped markedly since the late 1970s. Liberal politicians tend to choose the drug issue as the most profitable one on which to abandon their liberal principles and prove their tough-on-crime credentials. Even the civil liberties unions shy away from this issue, limiting their input primarily to the drug-testing debate. The minority communities in the ghetto, for whom repeal of the drug laws promises the greatest benefits, fail to recognize the costs of the drug prohibition policies for what they are. And typical middle-class Americans, who hope only that their children will not succumb to drug abuse, tend to favor any measures that they believe will make illegal drugs less accessible to them.

The few scholars who have spoken out in favor of repeal are primarily from the conservative end of the political spectrum: the economists Milton Friedman and Gary Becker, the criminologist Ernest van den Haag, and the magazine editor William F. Buckley, Jr. However, there is also a significant silent constituency in favor of repeal found among the criminal justice officials and scholars, intelligence analysts, and military interdicters who have spent the most time thinking about the problem. More often than not, job-security considerations combined with an awareness that they can do little to change official policies ensure that their views remain discreet and off the record.

Among Latin American officials, the need for discretion in advocating repeal of some or all of the drug prohibition laws is only slightly less than in the United States. During the late 1970s, the Colombian National Association of Financial Institutions lobbied for the legalization of marijuana. More recently, numerous high-level Colombians, including a former justice minister, a former attorney general, and the current president of an appointed advisory group, the Council of State, Samuel Buitrago Hurtado, have spoken publicly in favor of legalizing and taxing the illicit drug industries. And in a potentially significant development, the Inter-American Dialogue, a group composed of prominent politicians, scholars, business leaders, and former high-level government officials from the United States, Latin America, and the Caribbean, has called for serious study of "selective legalization" as one approach for dealing with the inter-American drug problem.

There can be no guarantee, of course, that legalization would lead to better and healthier societies in either the short or the long run. Indeed, the possibility cannot be excluded that drug abuse would become more widespread than it is now. But that prospect is by no means a certainty. At the same time, it is certain that most of the costs of current drug policies would be reduced dramatically in both North and South America. If the objective of American and international drug control policy is to consider the costs not just of drug abuse but also of drug control measures, then it is essential to consider the legalization option.

Of course, there is no single legalization option. Legalization can mean a free market, or one closely regulated by the government, or even a government monopoly. Just consider the range of regulatory regimes for the control of alcohol that state and even municipal governments have devised. Nor does legalization imply an end to law enforcement, as the Bureau of Alcohol, Tobacco and Firearms can attest. Legalization under almost any regime, however, does promise many advantages over the current approach. Government expenditures on drug-law enforcement would drop dramatically. So would organized crime revenues. Between reduced expenditures on drug-law enforcement and increased revenues, raised by taxing drug consumers and producers, the net benefit to government treasuries in the United States would easily be many billions of dollars per year. In Latin America, the net benefits would be smaller in terms of dollars, perhaps only a few billion, but far greater in terms of social gains—less corruption, more law and order, and a strengthening of the role of government in society.

It is troubling to note the opposite trends in the purity of legal and illegal substances. The average tar content of cigarettes is declining as smokers seek relatively safer products. Similarly, alcohol drinkers are shifting away from hard liquor and toward wine and beer, motivated in good part by health concerns. During the same period, conversely, the average amount of THC, the primary psychoactive ingredient of marijuana, has increased significantly; the average purity of cocaine has risen from 12 per cent to 60 per cent; and smoking crack has become far more widespread. In addition, the spread of high-potency "black tar" heroin from Mexico has contributed to an increase in the drug's average purity. Government law enforcement efforts help explain these trends in that they place a premium on minimizing the bulk of the illicit product to avoid detection. But the increasing purity is also an indication of the failure of law enforcement efforts. Under a legal drug regime, government regulators could establish relatively low purity levels, thus reducing the potential for drug abuse and addiction. They also could ensure quality and provide warnings as to the potential dangers of the licit substances. A black market still would exist for higher purity and even more dangerous substances, but it would be a fraction of its current size. Given the option of obtaining reliable supplies from government-regulated vendors, few drug users would have much to gain by resorting to the black market. And the government could set drug prices at a level high enough to discourage consumption but low enough to minimize black market opportunities.

Of all the drugs that are currently illicit, marijuana perhaps presents the easiest case for repeal of the prohibition laws, in good part because it presents relatively few serious risks to users and is less dangerous in most respects than both alcohol and tobacco. Moreover, the available evidence indicates no apparent increase in marijuana use following the decriminalization of marijuana possession in about a dozen states during the late 1970s. In the Netherlands, which went even further during the 1970s in relaxing enforcement of marijuana laws, some studies indicate use of the drug has actually declined. Marijuana arrests may not account for most of the drug offenders in U.S. federal and state prisons, but they do account for most of the drug arrests as well as for a large portion of the money spent on local drug enforcement by municipal criminal justice systems and on interdiction by the Coast Guard and the military.

Cocaine, heroin, and the various amphetamines, barbiturates, and tranquilizers that people consume illegally present much tougher policy problems. If they were legally available at reasonable prices, would millions more Americans use and abuse them? Drawing comparisons with other countries and historical periods provides clues but no definitive answers for the simple reason that culture and personality often prove to be the most important determinants of how drugs are used in a society. Availability and price play important roles, but not as important as cultural variables. There is good reason to assume that even if all the illegal drugs were made legally available, the same cultural restraints that now keep most Americans from becoming drug abusers would persist and perhaps even strengthen.

No progress can be expected, however, until more people and governments realize the extent of the costs exacted by current drug control policies. Every once in a while, a commission appointed to study a public-policy problem actually makes a difference. One such example was the Wickersham commission appointed by President Herbert Hoover in 1929 to evaluate the state of law enforcement and especially Prohibition in the United States. Its report played an important role in educating Americans about the limits and costs of Prohibition and helped shape the national debate that preceded the repeal of the 18th Amendment.

A similar commission, composed of North and South Americans, could evaluate the costs and benefits, as well as the potential and limits, of the international drug control regime. Unlike the recently created White House Conference for a Drug Free America, this commission could examine the entire range of options for reducing not just drug abuse but also the costs of drug prohibition policies. It would not begin its investigation, as the White House Conference has, with the unquestioned assumption that any use of illicit drugs is by definition drug abuse. Nor would it automatically assume that increased law enforcement and increasingly harsh criminal sanctions can produce a more effective drug control strategy. Rather, its mandate would include intensive scrutiny of the very assumptions that underlie current drug policies. For instance, the commission could make recommendations on how to deal more effectively with the violence, crime, and corruption that stem in good part from current drug prohibition strategies. In short, it would be an inter-American commission mandated to evaluate the value and effectiveness of current drug control strategies and to consider any and all alternatives.

In the final analysis, the drug problem remains an international problem that needs international solutions. Latin American governments realize the consequences for their countries of the U.S.-inspired policies, but they are unable to offer alternatives. They are hampered not only by their historical incapacity for concerted action but also by their recognition that the drug issue is one on which the U.S. government is liable to act impulsively, and even irrationally, to the detriment of everyone's interests. So rather than seek more effective and less costly drug policies, the Latin American governments find themselves torn between trying to appease their powerful neighbor to the north and trying to minimize the harmful consequences of a problem that lies beyond their control. Publicly they proclaim their adherence to the chimerical objectives of eliminating illicit drug production and use. But in practice they pursue "drug control" policies that really are nothing more than damage-limitation strategies designed to keep the drug traffickers from taking over their countries and the U.S. government from striking out at or abandoning them.

One of the most important steps the U.S. government could take, therefore, would be to let the Latin Americans evaluate their own best interests independent of U.S. demands. If they determine that their overall interests are best served by policies designed not to suppress but to control and regulate the production of marijuana and cocaine, then the U.S. government should be willing to consider policy alternatives that acknowledge those interests. Indeed, it is far from certain that the interests of the United States in this regard necessarily conflict with those of Latin America. For U.S. interests lie not only in reducing the costs of drug prohibition policies abroad but also in developing alternatives to a drug control policy that has proved both largely unsuccessful and increasingly costly at home.

TESTIMONY OF

SUE RUSCHE

DIRECTOR
NATIONAL DRUG INFORMATION CENTER OF FAMILIES IN ACTION
ATLANTA, GEORGIA
AND AUTHOR OF
"STRAIGHT TALK ON DRUGS"
A TWICE WEEKLY NEWSPAPER COLUMN ON DRUG AND ALCOHOL ABUSE
SYNDICATED BY KING FEATURES, INC.

BEFORE THE

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL
U.S. HOUSE OF REPRESENTATIVES
WASHINGTON D.C.

AT HEARINGS ON
THE LEGALIZATION OF DRUGS

SEPTEMBER 29, 1988

TESTIMONY OF SUE RUSCHE

I would like to begin my testimony by commending you, Mr. Chairman, for your outstanding leadership in focusing America's attention on the problem of drug abuse. The nation owes you its gratitude for the work you have done as Chairman of the Select Committee on Narcotics Abuse and Control, for the Anti-Drug Abuse Act of 1986 and the extension of that Act Congress is currently considering, and for ensuring that, through these hearings, we have a free and open debate on drug legalization.

I would also like to thank you and Representative Gilman for contributing, along with 23 other national leaders, "Arguments Against Legalizing Drugs" to the September issue of our publication, Drug Abuse Update. We are getting calls from people all across the nation requesting copies of that issue as they try to reason their way through the legalization debate.

Finally, I want to thank you, both as a woman and as one of many leaders of the eleven-year-old, family-based prevention movement, for including me in these hearings. Up to this point, women and families have been shut out of the legalization debate, which is too bad. We have gained insights from preventing drug abuse in our families and in our communities for more than a decade that policy makers and the public need to hear, as various solutions to the drug-abuse problem are examined.

I would like to share a few of those insights here today, first by examining some of the arguments legalization proponents put forth and then by proposing a possible solution to the problem.

FALLACIES CONTAINED IN LEGALIZATION ARGUMENTS

To support their case, legalization proponents make many arguments for legalization that are either misleading or incorrect. These include:

LEGALIZATION ARGUMENT NUMBER ONE:
"ONLY 3,562 DRUG DEATHS OCCUR NATIONWIDE EACH YEAR."

This is a misreading of the data collected by the Drug Abuse Warning Network (DAWN). While it is true that the DAWN data report a total of 3,562 deaths for 1985, the DAWN system clearly points out that these data come from only 26 cities in the United States. They are by no means a national total. (New York, for example, is excluded.) The total number of drug deaths is unknown, because no agency collects that data.

Furthermore, the 3,562 deaths reported in 26 cities were overdose deaths only, people who died with drugs in their systems.

The figure does not include people killed in drug-related murders. It doesn't include people killed in accidents caused by drug users. It doesn't include children killed from injuries inflicted by drug-abusing parents, or infants born to drug-abusing mothers too drug-damaged to survive.

It does not include deaths from AIDS contracted through IV drug abuse, nor deaths from AIDS contracted from a sexual partner who injects drugs, nor deaths from AIDS acquired from having sex with multiple partners as a consequence of cocaine and other drug addiction, nor deaths from AIDS passed on to infants by drug-using, AIDS-infected mothers.

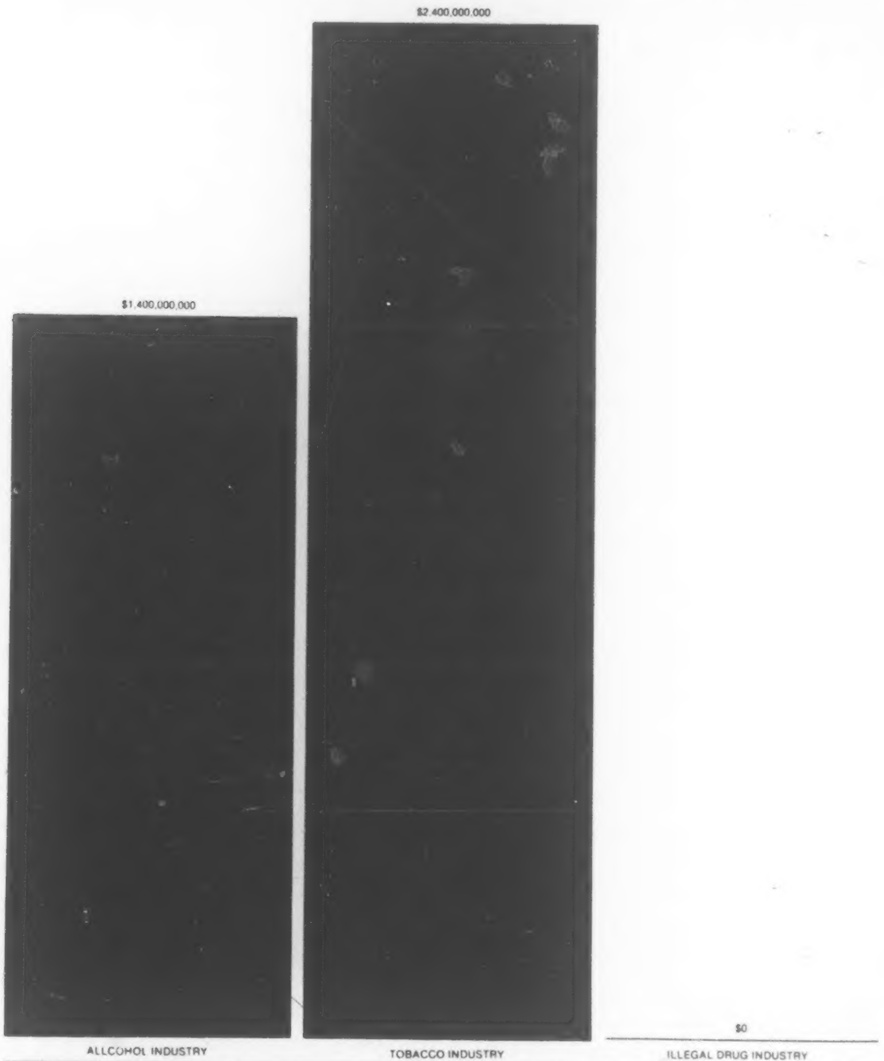
The best estimate of how many people drugs kill each year was made in 1980, before AIDS, and that estimate was 30,000 drug-related deaths. (1) It defies logic to believe that drugs kill fewer people today than eight years ago.

LEGALIZATION ARGUMENT NUMBER TWO:
"SMOKING IS GOING DOWN EVEN THOUGH CIGARETTES ARE LEGAL."

This is true, but it is not the whole truth. Smoking is decreasing among the college-educated, but it is increasing among young people, minorities and women. The tobacco industry directs a disproportionately large share of the $2.4 billion it spends on advertising each year towards young people, minorities and women. Can anyone doubt a relationship? Does anyone think a legal cocaine industry wouldn't t do the same?

LEGALIZATION ARGUMENT NUMBER THREE:

ANNUAL ADVERTISING EXPENDITURES, BY DRUG*



*1986 Sources The Bottom Line Vol 8 No 3, 1987 p 6 Federal Trade Commission

"ALCOHOL IS LEGAL BUT WE DON'T SELL IT TO YOUNG PEOPLE."

Americans incorrectly believe that underage drinkers get alcohol from their parents, or from someone older who buys it for them. Few realize how easily youngsters buy it themselves. In one year alone, our county police made 72 cases and obtained 52 convictions (most of the others were nolo pleas) against supermarkets, convenience stores and gas stations which sold alcohol to minors in violation of the law. Our county is one of a handful that has taken courageous steps to change this. Throughout the nation, however, alcohol sales to minors occur routinely, as sales clerks either fail to ask for identification to verify age or look the other way when obviously underage young people present fake IDs as "proof" that they are of legal age. (See Appendix).

Moreover, like the tobacco industry, the alcohol industry spends $1.4 billion in advertising that more often than not targets children and teenagers. This can be seen in the large number of beer commercials that feature rock stars young people idolize, in the placement of these commercials on radio and TV stations listened to or watched exclusively by young people (i.e. FM rock stations, MTV, etc.), in Annheuser Busch's marketing of Spuds MacKenzie dolls, t-shirts in children's sizes, etc., and in the placement of wine coolers on grocery-store shelves between bottled waters and soft drinks. It is little wonder that 79 percent of fourth, fifth and sixth graders don't know wine coolers contain alcohol (2), or that 8- to 12-year-olds can recognize, and spell correctly, more brands of beer than U.S. presidents. (3)

If we can't prevent an alcohol industry from selling to young people--over the counter and over the air waves, how can we expect to prevent an opiate industry from doing the same?

LEGALIZATION ARGUMENT NUMBER FOUR:
"WE LIVE WITH CIGARETTES AND ALCOHOL; WE CAN LIVE WITH DRUGS."

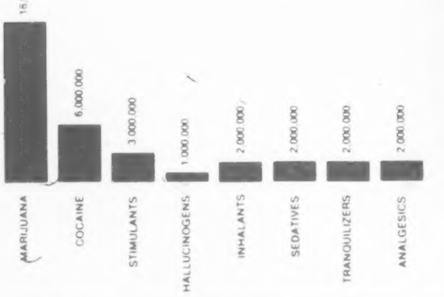
Legalization proponents offer the tobacco and alcohol model as proof that we can learn to live with legal marijuana, cocaine and other drugs. After all, they say, our two legal drugs kill more people than all illegal drugs combined, implying that illegal drugs are less harmful than alcohol and tobacco.

In reality, illegal drugs are at least as harmful, if not more harmful, than alcohol and tobacco. Illegal drugs kill fewer people only because fewer people use them. Keeping them illegal holds use down: 18 million marijuana users compared to 116 million alcohol users; 6 million cocaine users compared to 60 million tobacco users. (4)

The single greatest difference between legal and illegal drugs is that illegal drugs generate no profits to spend on advertising and marketing. Once a democratic society legalizes drugs, the forces of free trade and free speech will take over. Cocaine, marijuana, heroin, PCP, LSD, and other currently illegal

NUMBER OF AMERICANS WHO USE ILLEGAL DRUGS

(BARS REPRESENT MILLIONS OF USERS)



NUMBER OF AMERICANS WHO USE LEGAL DRUGS

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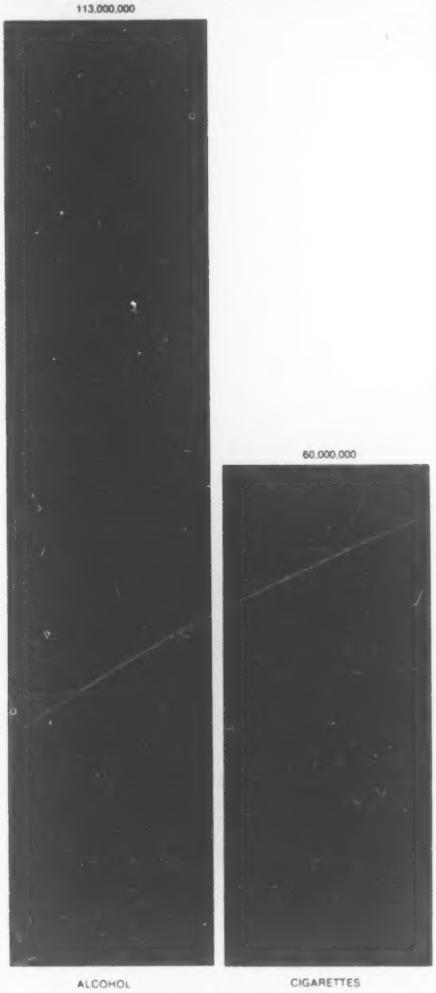


drugs will be mass-marketed, as alcohol and tobacco are mass-marketed today. Far more people will use newly legalized drugs and far more people will die.

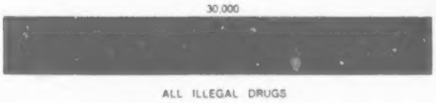
Finally, the assertion that our experience with alcohol and tobacco presents a model from which we should take comfort, as proponents try to talk us into legalizing other drugs, is perhaps their most cynical argument of all. Alcohol is the leading cause of death among young people in the United States, deaths which occur in alcohol-related homicides, suicides and accidents (by no means all of which occur in cars). (See Appendix). Alcohol kills a total of 100,000 people annually, while tobacco kills between 350,000 and 500,000 more people each year, according to various estimates. These numbers are almost too large to comprehend.

One way to try to grasp them is this: A few blocks from here stands a wall which records the names of every person killed in Vietnam. We would have to build two such walls each year to hold the names of Americans killed by alcohol and between seven and ten more walls each year to list those killed by tobacco. While legalization proponents claim that we live with alcohol and tobacco, the family-based prevention movement has been trying to get the nation to see that we die with alcohol and tobacco, in numbers that we are emphatically no longer willing to tolerate.

In light of this, can anyone seriously suggest that our

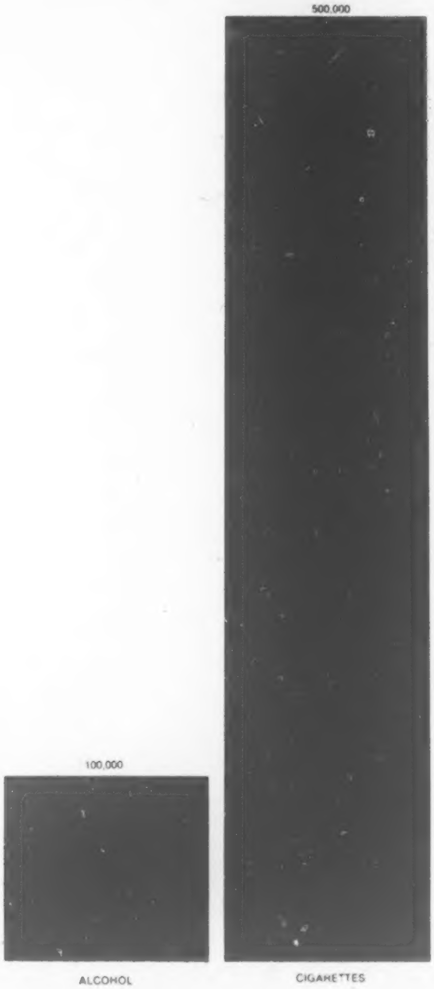
NUMBER OF AMERICANS KILLED BY ILLEGAL DRUGS

(BARS REPRESENT THOUSANDS OF USERS)



NUMBER OF AMERICANS KILLED BY LEGAL DRUGS

(BARS REPRESENT THOUSANDS OF USERS)



nation and its families would be willing to tolerate even more deaths from legal cocaine, crack, heroin, other opiates, PCP, nitrous oxide, other anesthetics, LSD, other hallucinogens, butyl nitrite, other inhalants, marijuana, hashish, Ecstasy, other designer drugs, Quaaludes, speed and other stimulants?

LEGALIZATION ARGUMENT NUMBER FIVE:
"TAXES FROM LEGAL DRUGS CAN BE USED FOR EDUCATION AND TREATMENT."

This sounds like a good idea. It is such a good idea, in fact, that we should study our alcohol and tobacco model to determine how many tax revenues from it are used for education and treatment. The answer is none. In fact, the last time Congress increased alcohol and tobacco taxes was in the 1950s.

Some of the profits society's two legal drugs generate are used to support highly effective lobbying efforts to defeat legislation that might affect them negatively, as well as to wage campaigns of misinformation. Two examples are both industries' successful effort for over a quarter of a century to prevent any increase in federal excise taxes on their products and the tobacco industry's claim that there is still no conclusive proof that smoking causes cancer.

Do we really want to put in place more drug industries whose profits will enable them to carry out similar efforts?

LEGALIZATION ARGUMENT NUMBER SIX: "LEGALIZATION WILL TAKE THE PROFITS OUT OF DRUGS."

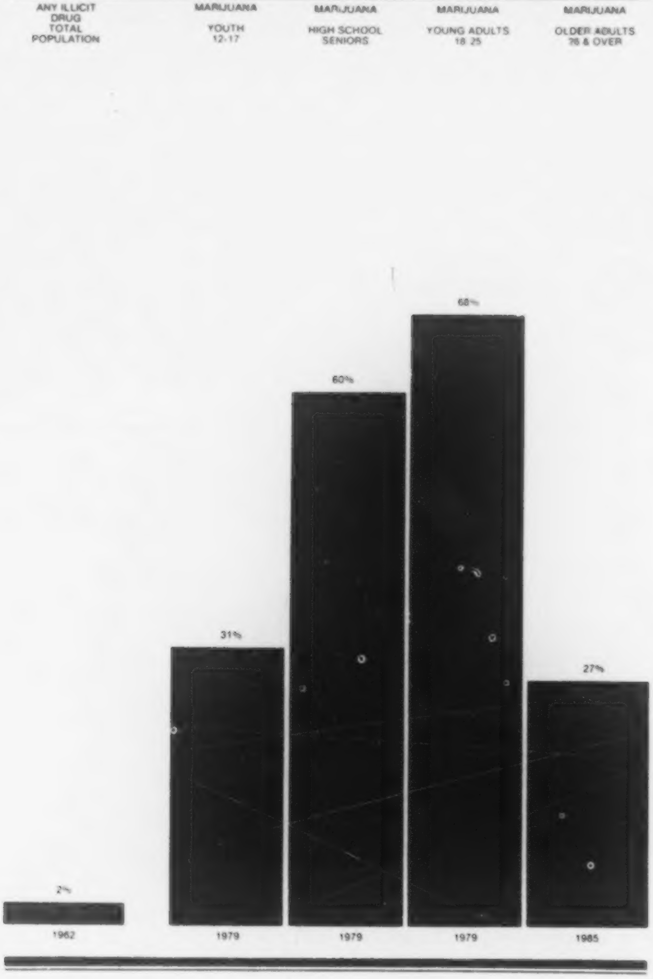
Here legalization proponents show how little they understand economic theories of supply and demand. What drives prices down is increased supply which occurs as the result of mass production. What keeps prices down is increased demand which occurs as the result of mass marketing. When both supply and demand increase, profits go UP, not down.

Legalization will not eliminate profits. It will simply shift them--out of the pockets of traffickers and into the hands of legitimate businesses. Drugs will be driven off the streets of America--straight into the shops and stores of America. Is this what we really want?

LEGALIZATION ARGUMENT NUMBER SEVEN: "LEGALIZATION WILL END CRIME."

Again legalization proponents tell only half the story. Legalization most likely will end crimes associated with drug dealing and trafficking. But it will increase crimes committed by people under the influence of drugs, as more and more people use them. Overt crimes such as drug-related violence, murder, wife-beating, child abuse, sexual assault, driving while intoxicated, etc. will rise. And the emotional wreckage produced among children of drug abusers will equal and probably exceed that produced among children of alcoholics.

DRUG USE IN THE U.S.: 1962 COMPARED TO PEAK YEAR



I am as eager as the next frustrated American to want to be able to live in my neighborhood without fear of being robbed or murdered by drug dealers, traffickers or addicts seeking money for their next fix. But safe neighborhoods won't be much good if families aren't safe and families cannot be safe when addiction drives one family member to physically or emotionally brutalize another. And safe neighborhoods aren't much good when the streets that run through them are filled with drivers intoxicated on drugs as well as alcohol.

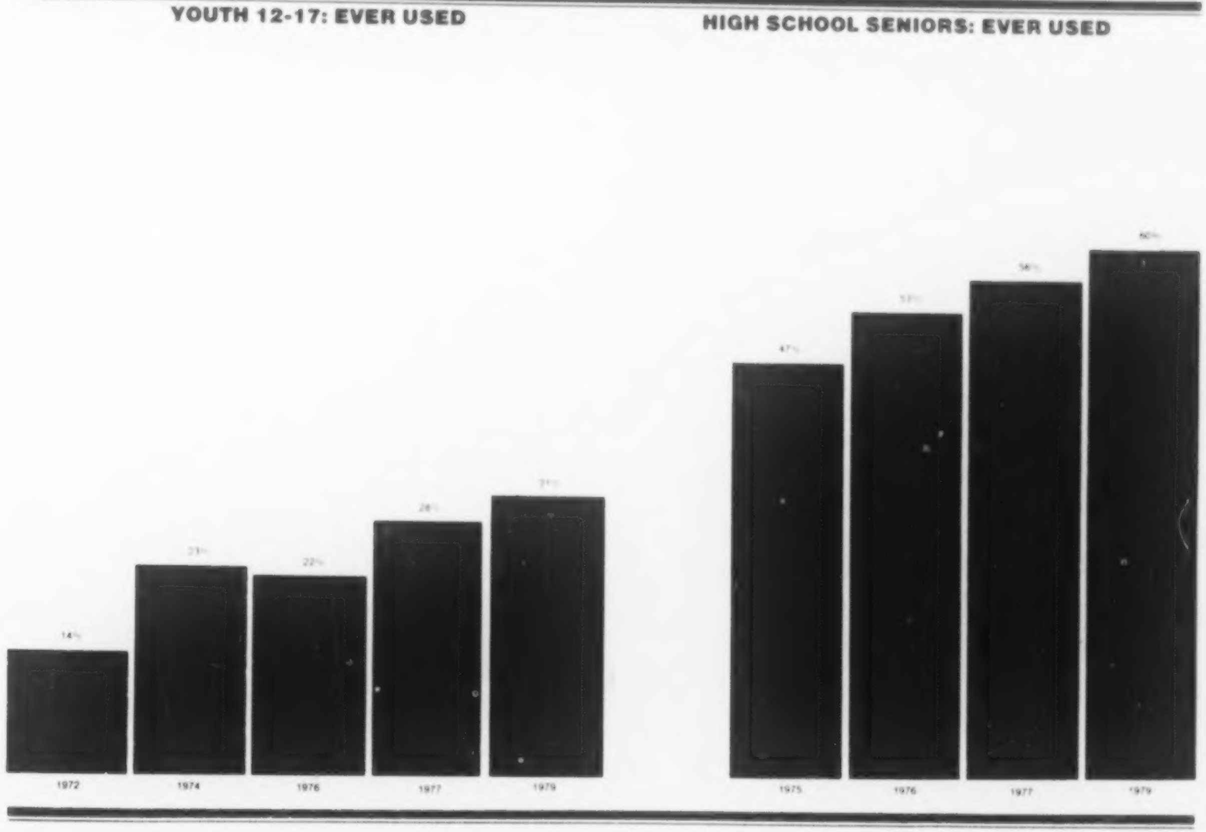
LEGALIZATION ARGUMENT NUMBER EIGHT:
"WE HAVE ALWAYS BEEN A DRUG-USING SOCIETY."

This is simply not true. As recently as 1962, less that TWO PERCENT of the entire U.S. population had had ANY experience with any illicit drug. (5) Our current drug epidemic has taken place in just 26 years.

LEGALIZATION ARGUMENT NUMBER NINE:
"DECRIMINALIZATION WON'T INCREASE USE."

This also is untrue, and we have a model to study. It is a model that legalization proponents ignore, never refer to and pretend doesn't exist. Between 1972 and 1978, eleven states in this country decriminalized marijuana. Advocates who lobbied states in behalf of decrim--many of them lobbying here today for legalization--insisted then that decriminalization would not increase use. But it did. During the decrim years, marijuana use rose 125 percent among young adults, 137 percent among high

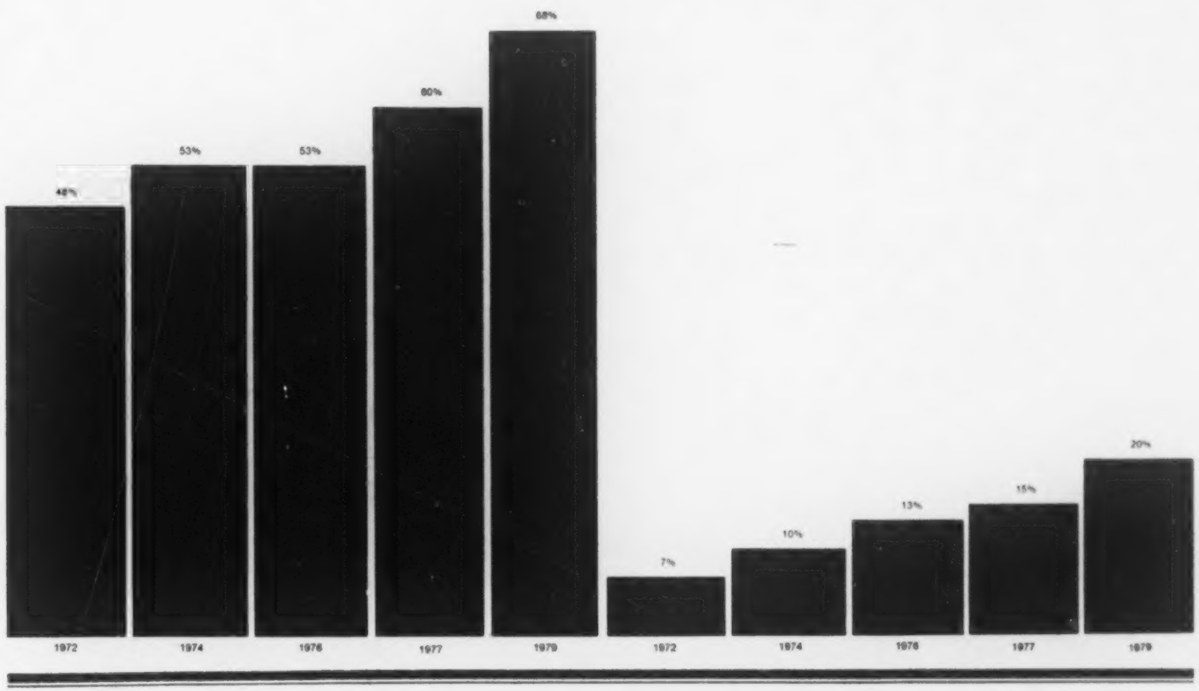
MARIJUANA USE DURING DECRIMMALIZATION 1972-1979



MARIJUANA USE DURING DECRIMMALIZATION 1972-1979

YOUNG ADULTS 18-25: EVER USED

OLDER ADULTS 26 & OVER: EVER USED



school seniors, 200 percent among older adults, and 240 percent among teenagers. Interestingly, marijuana use in this country peaked one year after the eleventh--and final-- state decriminalized.

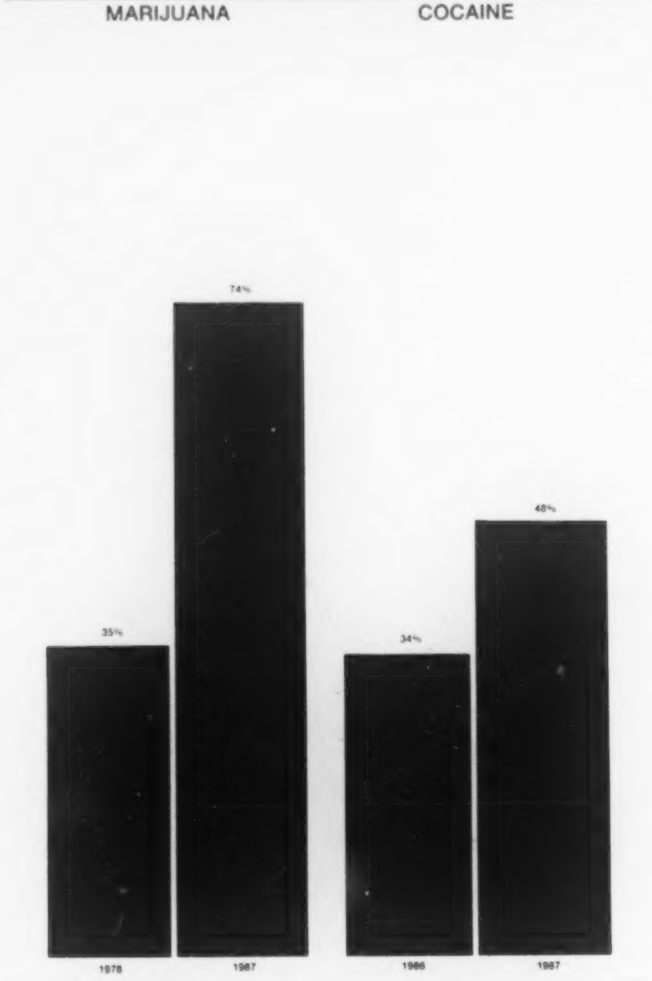
LEGALIZATION ARGUMENT NUMBER TEN:
"DRUG ABUSE IS NOW WORSE THAN IT'S EVER BEEN."

This is not true either. With only a few exceptions, drug abuse among all age groups has actually leveled off or begun to decline. The most dramatic examples of this can be found among high school seniors among whom daily marijuana use has been driven down from 11 percent in 1978 to 3 percent last year. The number of seniors who perceive marijuana as harmful increased during this same time--from 35 percent in 1978 to an astounding 74 percent in 1987.

A similar phenomenon has occured with respect to seniors' use of cocaine. It dropped one third in one year, from 6 percent in 1986 to 4 percent in 1987. A similar rise also occurred in seniors' perception that using cocaine even once or twice could be harmful--from 34 percent in 1986 to 48 percent in 1987.

Does this mean we don't have a drug crisis? No. It means we have a drug solution, if only we will pay attention to it. For more than a decade, family-based prevention groups led by parents, with precious little funding, have been driving drug abuse down. How?

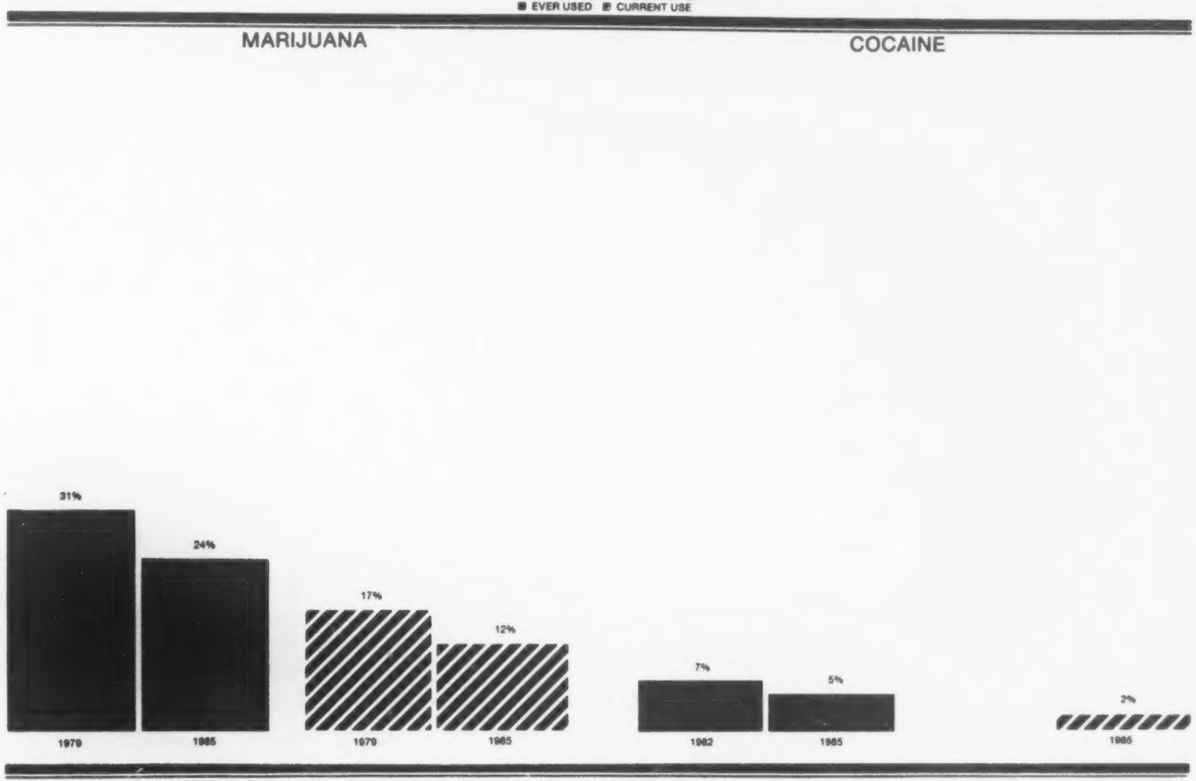
SENIORS WHO THINK DRUGS ARE HARMFUL



First they drug-proofed their families. They educated themselves and their kids about the ways drugs hurt people. They articulated their expectations of kids: no drugs ever, no tobacco or alcohol until you're of legal age. Many parents quit smoking. Still more modified their drinking or quit altogether. The few who indulged in illicit drugs stopped. They set limits for youngsters they were willing to enforce. They taught kids to obey the law and obeyed it themselves. They set family rules that reinforced, rather than contradicted, the law. They obtained treatment for family members already caught in chemical dependency and didn't stop until everyone in the family was drug-free.

Then they drug-proofed their communities. They lobbied for laws that banned 30,000 head shops, which served as learning centers for drug abusers, and closed them down. They fought against decriminalization and won. They insisted that drug-education materials teach children to turn away from drugs, not use them "responsibly." They set up neighborhood watches to help police arrest drug pushers, court watches to make sure pushers and drunk drivers were held accountable for their crimes. They came to understand that citizens have responsibilities as well as rights and must be willing to testify against law-breakers. They pressured public officials to enforce laws against alcohol and tobacco sales to underage youngsters.

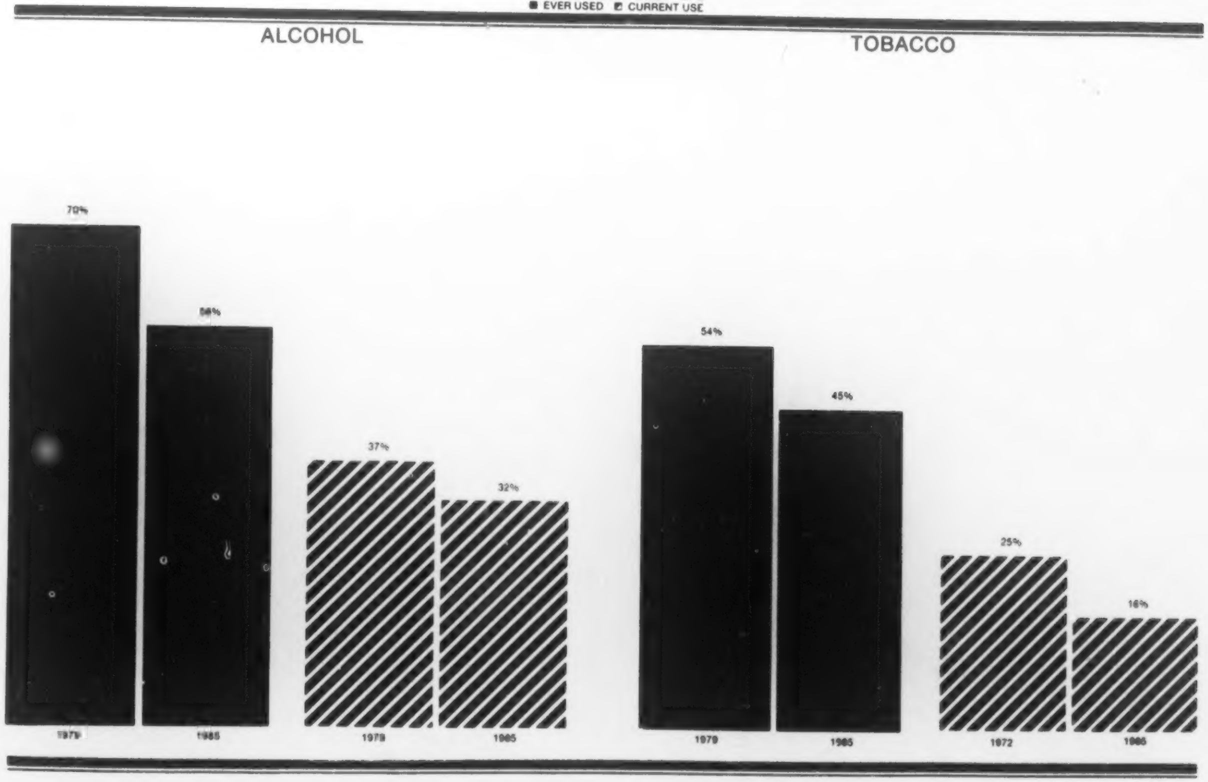
DRUG USE IN THE U.S., 1972-1985:
PEAK YEAR COMPARED TO MOST RECENT YEAR
YOUTH 12-17



A SINGLE BAR IN 1985 MEANS 1985 IS PEAK YEAR

DRUG USE IN THE U.S., 1972-1985: PEAK YEAR COMPARED TO MOST RECENT YEAR

YOUTH 12-17



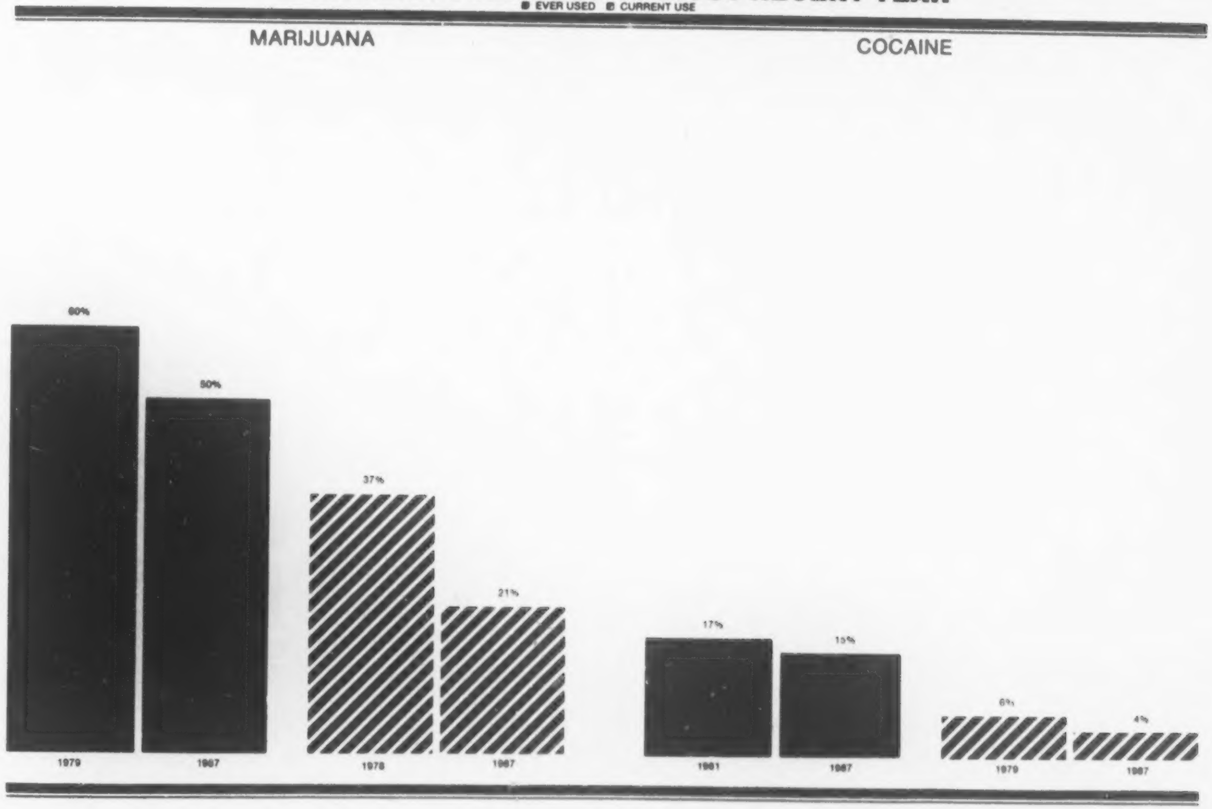
In short, they turned drug abuse around. Their families and their communities became stronger as a result.

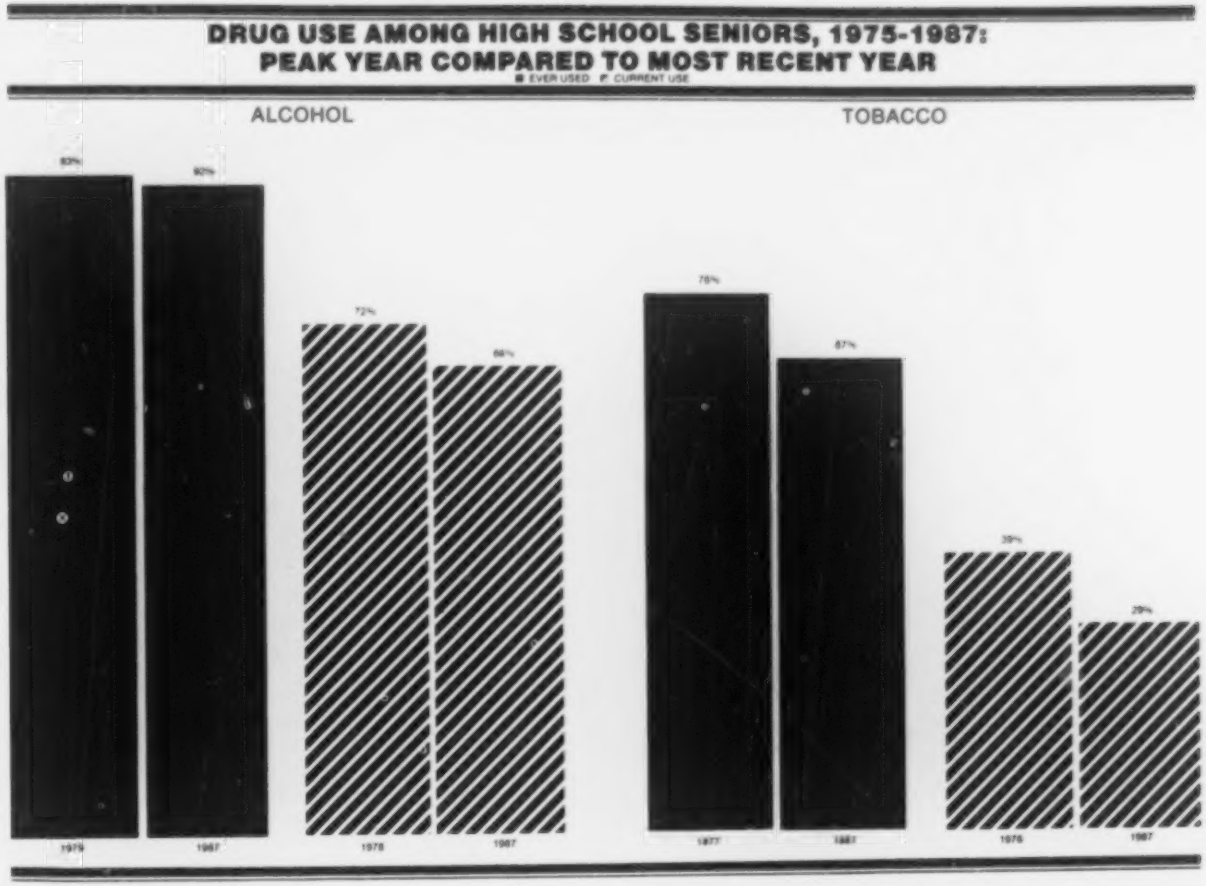
ONE SOLUTION: CREATE A NATIONAL DRUG CORPS

The National Drug Information Center of Families in Action proposes that we build on those strengths by creating a National Drug Corps, modeled after the Peace Corps, to empower more families to reduce drug abuse even further. The National Drug Corps will provide mothers, fathers, young people and others with an opportunity to give two years of service to their country. Drug Corps volunteers will be trained in the successful drug-abuse-prevention techniques developed over the past 11 years by such family-based prevention organizations as Families in Action, the National Federation of Parents for Drug-Free Youth, Mothers Against Drunk Driving, the Institute on Black Chemical Abuse, the National Association of Children of Alcoholics, National Asian-Pacific-American Families Against Drug Abuse, National Hispanic Families Against Drugs, the Alkali Lake Indian Band and scores of others. After training, Drug Corps volunteers will be returned home to prevent drug abuse first in their families and then in their communities, block by block.

Key to the success of the prevention movement has been that families themselves have taken charge and worked for change. The National Drug Corps will build on this concept of self-determination for families and on the initial gains, outlined above, that family-based prevention groups have achieved thus

DRUG USE AMONG HIGH SCHOOL SENIORS, 1975-1987: PEAK YEAR COMPARED TO MOST RECENT YEAR





DRUG USE AMONG HIGH SCHOOL SENIORS, 1975-1987: PEAK YEAR COMPARED TO MOST RECENT YEAR far.

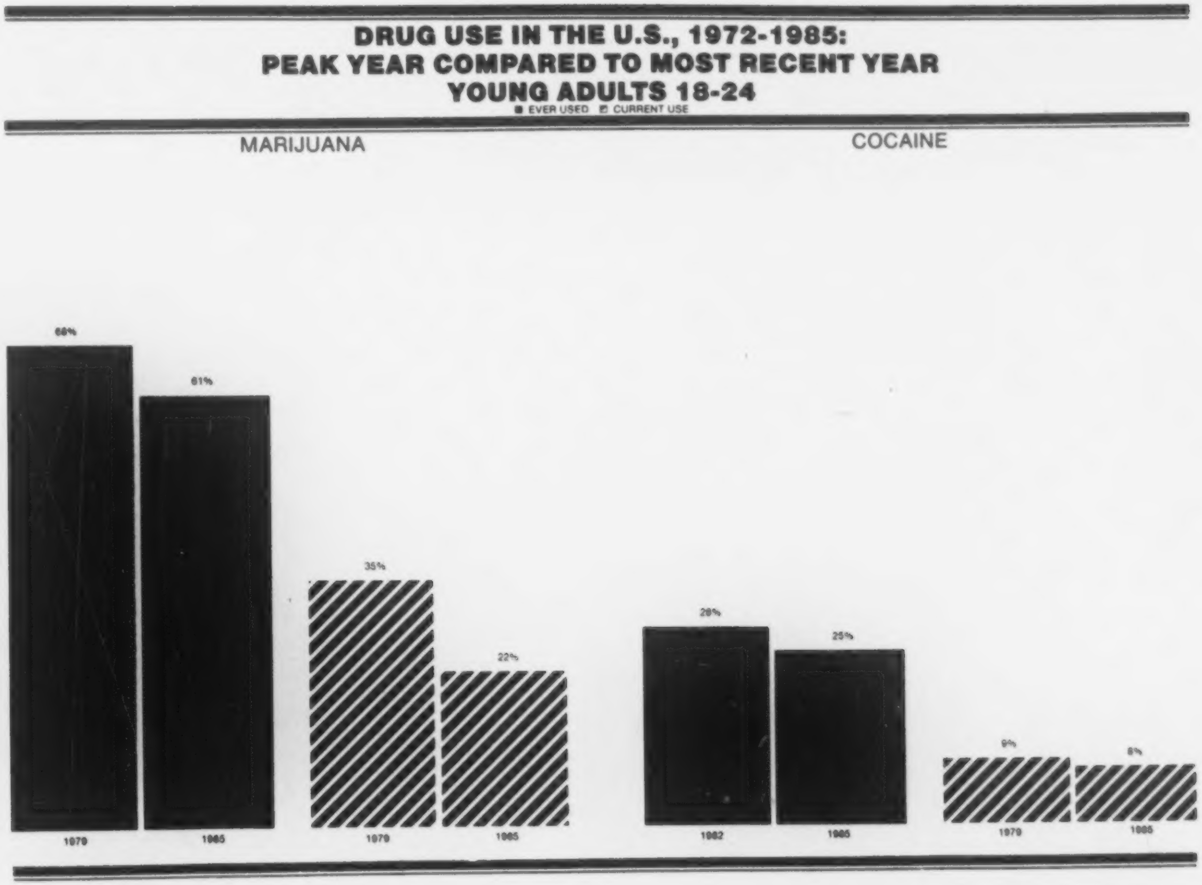
The goals, objectives and a few examples of activities of the National Drug Corps are listed below:

I. STRENGTHEN FAMILIES.

1. Improve parenting skills.
2. Create incentives to reward constructive parenting.
3. Develop alternatives to drugs for children.
4. Develop alternatives to drugs for adults.

The Atlanta chapter of the organization known as 100 Black Men provides one example of ways to create alternatives to drugs for children. This organization adopted an eighth-grade class in an inner-city Atlanta school. Each member of the organization serves as a mentor to a particular student in the class and has promised to send that student to college if he or she graduates from high school. At the end of the first year of the project, the drop-out rate has decreased, academic grades have improved and drug abuse has declined or stopped. The National Drug Corps will ask organizations such as 100 Black Men to train other service organizations to expand this effort.

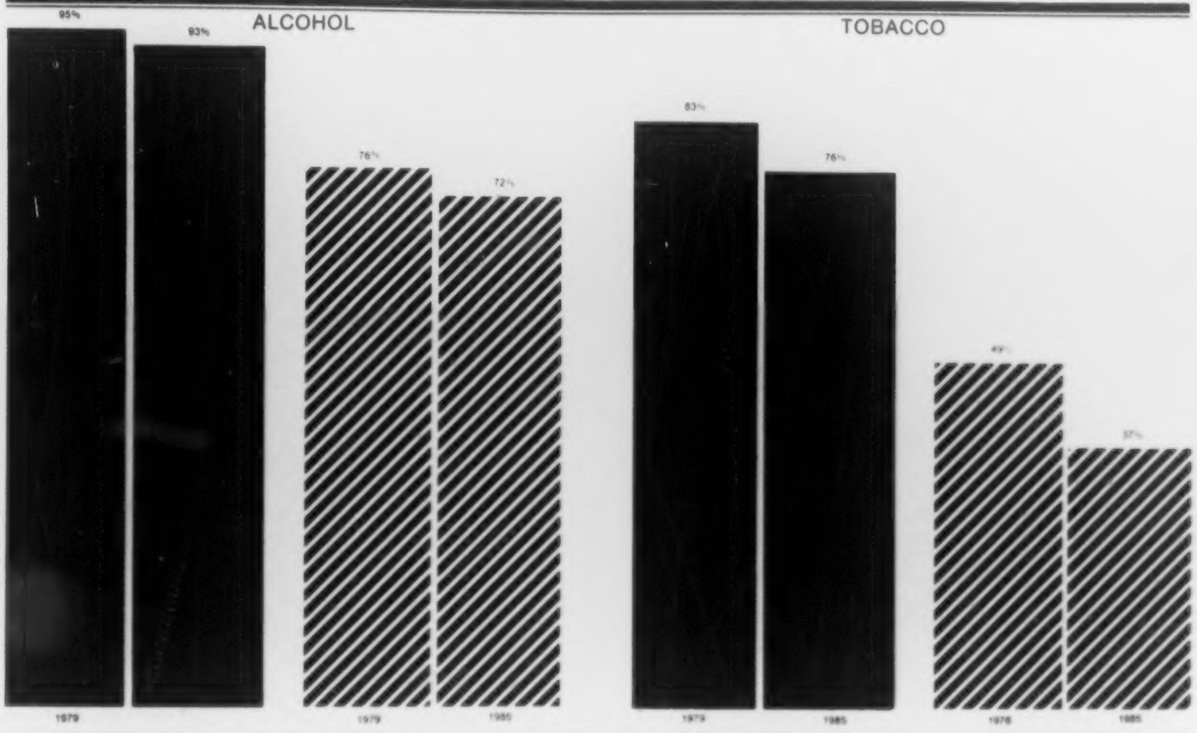
A black businessman in Los Angeles, owner of a pipe-fitting company, hired members of a violent gang to protect equipment his company had to leave out over several nights in a neighborhood the gang controlled. When the job was completed, gang members



DRUG USE IN THE U.S., 1972-1985:
PEAK YEAR COMPARED TO MOST RECENT YEAR
YOUNG ADULTS 18-24

DRUG USE IN THE U.S., 1972-1985: PEAK YEAR COMPARED TO MOST RECENT YEAR YOUNG ADULTS 18-24

■ EVER USED ▨ CURRENT USE



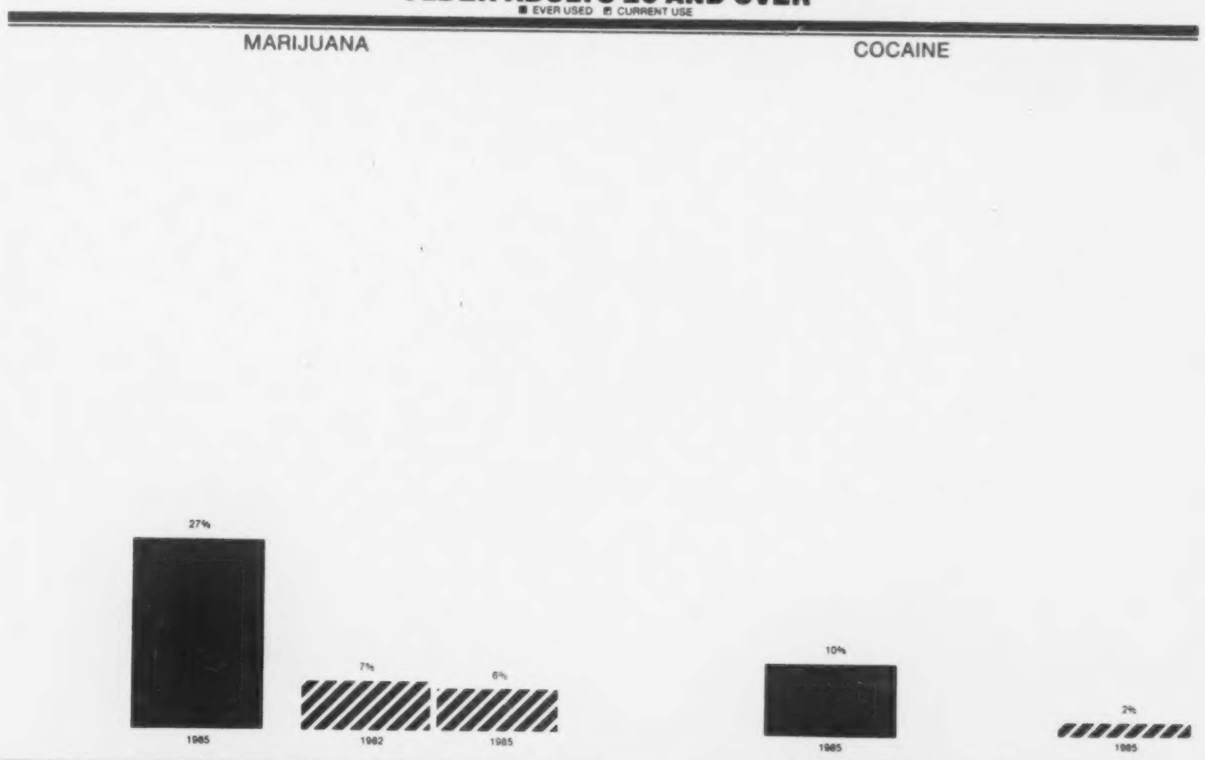
asked the businessman to hire and train them. They were "tired of earning dirty money" through drug-dealing, they said. As a result, several young men have left the gang and now work at honest jobs. The Drug Corps will ask such business people to train other businesses to expand this effort.

II. INVOLVE COMMUNITIES IN SUPPORTING FAMILIES.

1. Empower families to exercise responsibilities of citizenship.
2. Maximize existing resources in communities by fostering coordination and filling in gaps.
3. Target training and resources to special needs of individual communities.

Law enforcement officers are training citizens in Neighborhood Watch groups to look out for and report drug-dealing. Families learn they have a responsibility not only to report law-breaking, but to testify against law-breakers as well. Family prevention groups teach that to protect children, parents must obey the law themselves and teach children to do the same. This applies to laws that prohibit drug use, dealing and trafficking, that prohibit alcohol and tobacco sales to minors, that prohibit driving under the influence, that require banks to report deposits larger than $10,000, etc. The National Drug Corps will build on the growing awareness among families that a democracy whose citizens routinely violate the law is a democracy that has lost its freedom.

DRUG USE IN THE U.S., 1972-1985: PEAK YEAR COMPARED TO MOST RECENT YEAR OLDER ADULTS 26 AND OVER



A SINGLE BAR IN 1985 MEANS 1985 IS PEAK YEAR

DRUG USE IN THE U.S., 1972-1985:
PEAK YEAR COMPARED TO MOST RECENT YEAR
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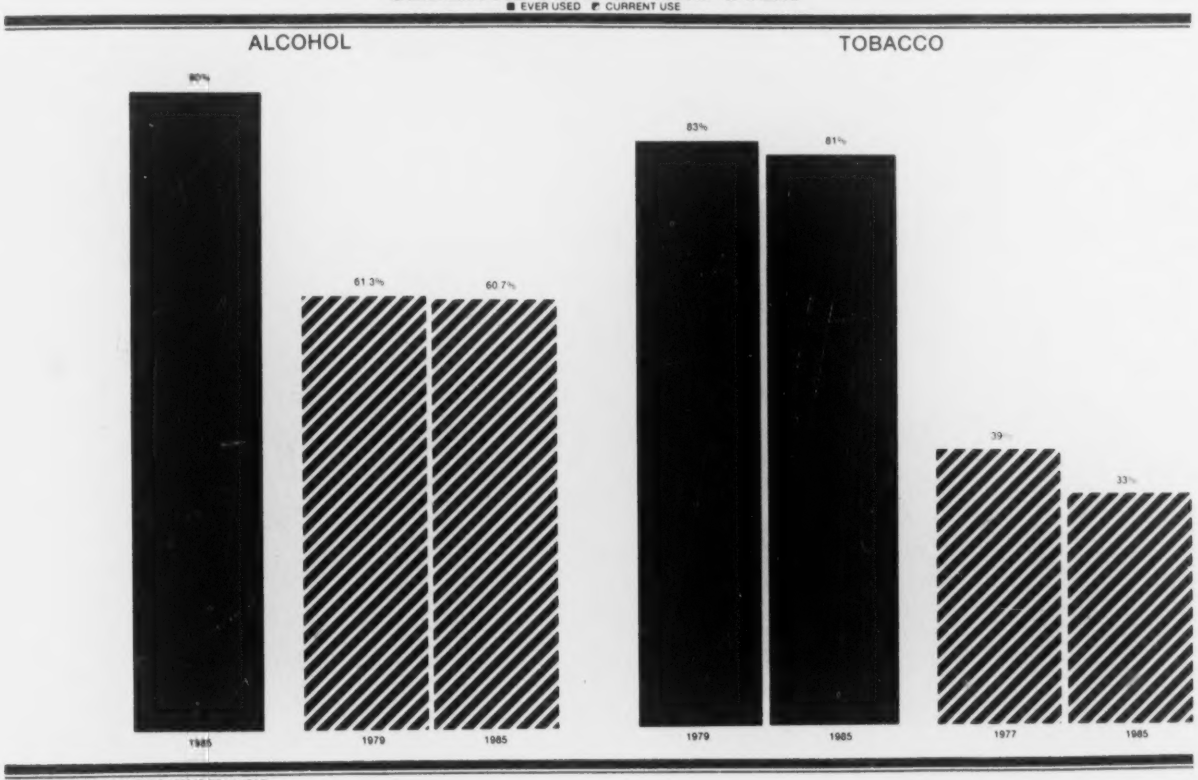

A SINGLE BAR IN 1985 MEANS 1985 IS PEAK YEAR

Private treatment centers in one city are forming a consortium to consolidate empty beds each has and will make them available to the state to provide treatment to patients currently on waiting lists for publicly funded treatment. The National Drug Corps will call for significant increases in funding for treatment, and, in addition, will model the approach being developed by the consortium to maximize use and minimize waste. It is our belief that the law must be used to put drug users in treatment and drug traffickers in prison.

The Alkalai Lake Indian Band in British Columbia went from 100 percent alcoholism to 95 percent sobriety in the span of a few years. Newly sober members of the Band renovate the houses of fellow tribespeople who enter treatment during the time they are hospitalized. The National Drug Corps will model this solution to assist drug-dependent people who are homeless or who live in substandard housing while they seek treatment to become drug-free. It will also ask the Alkalai Lake Indian Band to provide training to Native Americans, and others, who wish to model the Band's astonishing success at ridding itself of chemical dependency.

III. CREATE A PUBLIC/PRIVATE/VOLUNTARY PARTNERSHIP TO HELP FAMILIES RESPOND TO THE NATION'S DRUG PROBLEM

1. **Develop a long-range programmatic and financing plan.** Involve the three segments of the Partnership in the

planning process.

2. Coordinate efforts. Establish a series of mechanisms under which the public sector, private sector and voluntary agencies can contribute targeted resources to accomplish specific objectives and activities.
3. Pool financial resources. Establish a system of federal challenge grants that can be matched by state and local governments and by national, state and local businesses, foundations and nonprofit service organizations to finance the National Drug Corps.
4. Utilize untapped financial resources.
5. Obtain federal funds from these resources to initiate the National Drug Corps.

Churches throughout the United States currently reach out to immigrant families who arrive in this country unable to speak English and unfamiliar with American culture. Church families "adopt" immigrant families, teach them English, show them how to shop in American stores, help them find jobs and housing, help enroll the children in school and, in general, nurture these families until they can manage on their own. The National Drug Corps will encourage churches to expand this concept by asking families in their congregations to "adopt" American families who are disadvantaged by poverty, illiteracy, racial discrimination and drug dependence and to nurture them until these families are able to manage on their own.

Current criminal and civil forfeiture laws place significant funds derived from the seizure and sale of assets of convicted drug smugglers into federal, state, county and municipal treasuries. The National Drug Corps will urge legislation that will make it possible to seize ALL assets purchased with illicit drug profits, will vastly increase fines against banks that fail to report deposits larger than $10,000, will increase taxes on alcohol and tobacco products, and will designate those funds for drug prevention and education, treatment and law enforcement. As drug abuse is reduced, amounts of designated revenues to fight drug abuse will be reduced proportionately.

IV. REDUCE COSTS OF ASSISTING DYSFUNCTIONAL FAMILIES.

1. Conduct a comprehensive review of the total costs born by public, private and voluntary service-delivery systems (criminal-justice, social, health, and addiction services) that are the consequence of drug abuse in the family.
2. Work with all levels of government and the private sector to determine how to make systems changes that will meet families' needs and effect savings in the delivery of human services.
3. Initiate short-term and long-term evaluations of the outcomes and consequences of implementing the National Drug Corps.

Mr. Chairman, it is our belief that this nation has the knowledge and the power to stop drug abuse among those who have already started through intervention, treatment and rehabilitation and to prevent drug abuse among those who have not yet become involved with drugs through education and community action. The nation's families have shown us how to do this and have achieved impressive preliminary results, but families have been left out of the funding stream. The National Drug Corps provides a mechanism to bring families into the loop. It also provides a mechanism to support the family-based prevention groups that have achieved impressive results thus far by hiring them to train National Drug Corps volunteers. We urge you and this Committee to create a National Drug Corps as an alternative to legalizing drugs. We urge you to reject legalization, a solution that, in our view, would vastly increase the devastation and death Americans already suffer and that would disproportionately affect children, the poor and minorities.

TSTMNY

NOTES

1. R.T. Ravenholt, "Addiction Mortality in the United States, 1980: Tobacco, ALcohol and Other Substances," Population and Development Review 10., No. 4, December, 1984.

2. 1987 Weekly Reader Survey.

3. 1988 Survey, conducted by the Center for Science in the Public Interest.

4. All references to drug use throughout this testimony, including charts, come from two national surveys funded by the National Institute on Drug Abuse. Data on youth, young adults and older adults come from the National Household Survey on Drug Abuse, conducted in 1972, 1974, 1976, 1977, 1979, 1982 and 1985. Data on seniors come from the National High School Senior Survey, conducted annually since 1975. Most recent data available from this survey is for 1987.

5. "Highlights from the National Survey on Drug Abuse: 1977," National Institute on Drug Abuse, DHEW Publication No. (ADM) 70-620, p. 15.

FOR RELEASE WEEK OF DECEMBER 30, 1985 (Col.2)

STRAIGHT TALK ON DRUGS

by Sue Rusche

Teens Die Drinking, Not Driving

A television documentary will be coming to your town soon, if it hasn't already. It's called "Deadliest Weapon in America" and it's a powerful statement about drunk driving. It's powerful, that is, until it comes to the question of teenage drunk driving. There it falls into the all too familiar trap of asking teens to drink "responsibly" by not driving when they drink, rather than asking them not to drink at all because it's against the law.

It grieves me to say something negative about this documentary because one of the stories it tells is that of a personal friend, Cecil Alexander. On their way home from dinner one night a few years ago, Mr. and Mrs. Alexander were turning into their driveway when they were hit by a 16-year-old drunk driver whose license had already been suspended on a previous D.U.I. charge. Mrs. Alexander died an hour or so after the accident. Mr. Alexander still limps slightly from a badly injured leg that in spite of several operations refuses to work properly.

In memory of his wife, Mr. Alexander founded the Hermione Weil Alexander Committee to Combat Drugged and Drunken Driving. I serve on that Committee because I believe we must not let what happened to the Alexanders happen to anyone else in this country ever again. I should stress that neither Mr. Alexander nor the Committee had anything to do with making the documentary. I also want to stress that I'm sure the makers of the documentary had nothing but the best intentions.

But in "Deadliest Weapon in America," adults advise teenagers not to drive when they drink, rather than not to drink at all. An hour-long discussion that followed the documentary in Atlanta featured interviews with teenagers who impressed the television reporter with how "responsible" they were. "They really understand they shouldn't drive when they drink," she said.

The documentary, the adult advisors, the TV reporter, and the kids themselves all missed the point. An awful lot of time and energy went into a national effort to raise the drinking age to 21. Nothing in that law says it's illegal for teenagers to drink and drive. It says it's against the law for teenagers to drink, period.

As a nation we've convinced ourselves that the only problem with teenage drinking is drunk driving. If you can keep them out of cars when they drink, we say, it'll be OK. Until we recognize drunk driving is not the only problem we're still in deep trouble. So are our kids.

A recent examination of alcohol-related adolescent deaths in San Francisco, for example, revealed that over half had nothing to do with cars. Drinking or drunk teenagers drowned. They were murdered in fights. They committed suicide. They fell to their deaths from high places. More died in these ways than died in drunk-driving crashes.

Telling them not to drive when they drink would not have prevented one of those deaths.

The drinking-age law not only forbids teenagers to purchase, possess or use alcohol, it also prohibits stores from selling it to them. But as long as we ignore the law, stores will keep selling booze to kids. Big bucks are made from sales to teenagers. And alcohol makers, distributers and sellers are not the only ones who profit — so do city and county treasuries from the taxes those sales generate.

I don't think we have a chance of solving the complex problems that surround teenage drinking until we quit paying lip service to the drinking-age law and insist that parents, teenagers, merchants, local officials and even documentary makers take it seriously.

* * *

For a free copy of Fue Rusche's leaflet, "Twenty-five Most Frequently Asked Questions About Drug Abuse," send a self-addressed stamped envelope (Number 10) to her in care of this newspaper.

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FOR RELEASE THE WEEK OF JANUARY 27, 1986 (Col. 1)

STRAIGHT TALK ON DRUGS

by Sue Rusche

Alcohol Overdose Can Kill You

Q. We have just gone through the worst nightmare of our lives. We gave our 15-year-old daughter permission to go with a friend for a pizza supper and then to the movies. My husband dropped our daughter off at her friend's house and arranged to pick both girls up after the movie. As they were getting ready to leave for the pizza house, a boy and girl from their school, whom they knew only slightly, came by and invited the girls to a party. The girls accepted and got into the other kids' car.

On the way to the party, they stopped at a liquor store, located one block from their school. All of the kids are well below the legal drinking age (20 in our state), yet the store sold them two bottles of tequila and a bottle of high-proof bourbon.

As they continued on to the party, the kids taunted our daughter about the fact that she'd never been to a drinking party before. They told her that to be like them, and like the rest of the kids at the party, she would have to show them she could "handle it" by chugging the entire bottle of bourbon they'd bought. She did.

She became violently ill, so much so that the kids who brought her got scared and fled, leaving her to fend for herself. Even though they didn't know her, other kids at the party had sense enough to realize something was terribly wrong and called an ambulance.

The first we knew of this was when the hospital called with word that our daughter had been admitted and was in a coma. Her blood alcohol level was .39, nearly four times the legal level of intoxication. She was comatose for 10 hours, and was in intensive care for four days, but is all right now, thank God. A second teenager admitted to a hospital in an adjacent county that same weekend wasn't so lucky — he died of an alcohol overdose.

Why do stores sell alcohol to underage kids? What can we do to stop them?

A. Your daughter is lucky to be alive. A blood alcohol level of .4 or above can cause death from overdose. What's more, 20 to 30 ounces of one hour is a lethal dose. If the bottle of bourbon your daughter chugged was a fifth, it contained 25.6 ounces; a quart, 32 ounces; or a standard 750 milliliter bottle, 25.36 ounces. Whichever it was, you can see that, in chugging the whole bottle, your daughter consumed a lethal dose.

Sadly, yours is only one of many reports I've received of teenagers chugging large amounts of alcohol as some sort of misguided rite of passage. Teenagers (and their parents) need to know that consuming too much alcohol too quickly can kill them. One can overdose on alcohol just like any other drug.

Stores sell alcohol to underage kids because they make money from those sales. So do local governments, which makes it difficult to persuade them to enforce the law. In 1984, my county took in $4.5 million from beer taxes alone. My state raised $107.6 million in beer, wine and liquor taxes, fees for seller's licenses and fines.

Of course, not all of those sales were to minors. Authorities claim few, if any sales are. The ones I've talked to say kids get the alcohol they drink from their parents' liquor cabinets.

The high rate of alcoholism and problem drinking among teenagers and the fact that drunk driving is their leading cause of death indicate that parents' liquor cabinets are either extremely well-stocked or that more illegal sales are occurring than anyone wants to admit.

Because they are illegal, no records are kept, so it's impossible to prove how many alcohol sales are made to minors. But kids will tell you they can buy alcohol anywhere, that it's "easy to get."

What can be done to stop illegal sales? Exercise your rights — and responsibilities — as citizens. Form an Alcohol Task Force made up of concerned parents and community leaders. Find out who regulates alcohol sales in your city or town or county or state (usually it's a combination of state and local governments) and then put pressure on those officials to enforce the law.

* * *

Sue Rusche, author and national authority on drug abuse, answers questions from readers in her column. Write to her in care of this newspaper.

FOR RELEASE WEEK OF DECEMBER 30, 1985 (Col.1)

STRAIGHT TALK ON DRUGS

by Sue Rusche

Fake I.D. Sold to Kids

She called in a fury. Her family lives in one of the most prosperous sections of the city. Their two teenagers attend private day schools located in the area. She's active in the parents' council at the schools.

The drinking age in her state is 20. Shortly after class, two 14-year-old boys from her daughter's school ran into a teacher on their way out of a convenience store just down the block. Both boys carried six-packs of beer.

"That's one thing that gets me," she said. "It was so blatant. They didn't even try to cover up the beer with a grocery sack."

The teacher, dumbfounded, asked the boys where they got the beer. "Inside," they replied. She took them inside to talk to the clerk.

"These boys are 14 years old," the teacher said. "Did you just sell beer to them?" They had I.D., the clerk replied.

The teacher took the boys back to school and sought out the coach who handles discipline and represents the school on the parents' council.

"How can a 14-year-old get I.D. that says he's 20?" the coach asked the boys.

"You buy it at the I.D. store," they said.

"What I.D. store?" asked the coach.

The boys showed him one of their "Picture-I.D.'s," as they're called. At a glance it looked like a driver's license, something both boys are two years away from obtaining legally. In the corner was a color photo of the boy. The birth date printed on it showed he was 20. Closer inspection, the kind clerks perform before cashing personal checks, showed that it wasn't a driver's license. But we're not talking about stores protecting themselves from cashing bad checks. We're talking about stores protecting profits by selling alcohol to anyone who asks for it.

"After the coach brought this incident to the attention of the parent's council, I drove to the I.D. store," continued the mother. "On the way I noticed posters tacked to several telephone poles advertising the I.D. store, its address and phone number. The posters proliferated near the school.

"I went inside and talked to the owners — two little old ladies in their 70s who look like your grandmother," she said. "I asked them what proof of age they required to issue the $14 Picture-I.D.s they sell.

"They told me a valid driver's license, a birth certificate, or — and here's the kicker — a Social Security card. Social Security cards have no date," she said. "Babies can get Social Security cards."

The mother drove home and called police. They told her it's legal to sell I.D. So far, the officer said, police have had no indication these shops are selling fake I.D. to kids.

"You'd think a convenience store clerk could tell the difference between a 14-year-old and a 20-year-old," the mother said. "You'd think an I.D. shop owner could tell what a kid's up to when he comes in to buy a card that says he's 20.

"Technically nobody's breaking the law," she continued. "But in reality everybody is. Whatever happened to old-fashioned responsibility?"

What indeed?

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Sue Rusche, author and national authority on drug abuse, answers questions from readers in her column. Write to her in care of this newspaper.

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FROM KING FEATURES SYNDICATE INC., 235 EAST 45TH STREET, NEW YORK, N.Y. 10017

FOR RELEASE WEEK OF APRIL 11, 1988 (COL. 2)

STRAIGHT TALK ON DRUGS

COUNTERACT PEER PRESSURE TO WIN DRUG WAR

BY SUE RUSCHE

Two recent Washington Post stories say a lot about where we are with the war on drugs. One tells about Washington D.C. parents and educators who want public schools to institute uniforms as an antidote to drug abuse. The other describes a riot by intoxicated high school students celebrating spring break at a Texas beach.

In Washington an elementary school principal says attendance at her school is down because students "are out there dealing drugs to pay for expensive clothes." A school board member says students tell her a "typical" high school outfit consists of "gold earrings ($150), gold rope chains ($3,000), designer shoes and handbags ($200), designer jeans ($80 or more), and a leather fur-trimmed trench coat ($900)." Three school uniforms cost less than $100.

A second principal says his elementary school adopted a uniform policy earlier this year. Although public schools cannot legally force students to wear uniforms, within two weeks of the decision all students were wearing them. "I don't know if you know what peer pressure will do," he stated.

That's really the point. Peer pressure can be positive, as in this case, or negative, which is how we usually think of it. It's a powerful force in kids' lives, but we don't understand it. We know it's the pressure kids feel to be just like each other. But how do they determine that? Who sets the standard?

Why does a 4-year-old, too young yet to have peers, tell his mother with absolute certainty that the only thing going on his feet are brand-name running shoes? The only thing going in his mouth brand-name frosted flakes? What makes a teenager prefer an $80 pair of jeans over a $20 pair? A $3,000 gold chain over a $3,000 savings account for college?

Billions of dollars are spent each year to advertise products on television. You and I tune most of the sales pitches out and use our adult judgment to sort through the rest. Kids take them literally. And by the time they graduate from high school, they've seen one million commercials.

Without understanding how advertising feeds peer pressure, we have trouble seeing the need to counteract it. For any group of kids, whether peer pressure turns out to be positive, or negative, depends on the presence, or absence, of guidance from adults who care for them. The adults in the District are providing that guidance. They're saying to the kids, "You think you've got to wear $3,000 chains to school? Think again. What you do in school is more important than what you wear in school."

They're counteracting negative peer pressure with positive values. Adults who care for the kids who rioted during spring break failed to provide that guidance. The Post says most of the rioters were high school students, among 30,000 who flocked to Mustang Island for spring break. Four people were stabbed in the riot. Two police officers were injured. It took seven canisters of tear gas and more than 100 officers to break up the crowd. Two kids drowned when their car sped off a dock and sank in 25 feet of water.

"What you have down there is a tremendous amount of intoxication going on," explained a police officer. That's intoxication among kids several years away from the legal drinking age, too young to vacation on their own without adult supervision.

Of those one million TV commercials kids see by age 18, one hundred thousand are beer commercials. Not one says "For adults only." Until we can see the need to counteract the way beer commercials feed kids' peer pressure to drink, tragedies like the one on Mustang Island will continue. And unless we see the need to counteract negative peer pressure with positive values, we'll lose the war on drugs.

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FROM KING FEATURES SYNDICATE INC., 235 EAST 45TH STREET, NEW YORK, N.Y. 10017

FOR RELEASE THE WEEK OF SEPTEMBER 26, 1988 — (COL. 1)

STRAIGHT TALK ON DRUGS

FEW WOMEN ON NIGHTLINE DRUG DEBATE

BY SUE RUSCHE

I watched Nightline's debate on the legalization of drugs. In the three-and-a-half hour broadcast, all the panelists but one were men.

All the members of the audience who spoke at microphones were men. All but two callers were men. Women were simply shut out of the debate. So were the men who, with women, help lead the family-based prevention movement. The token woman on the panel, Dr. Shirley Thornton, an educator, made the best of the three or four minutes Ted Koppel let her speak, but it wasn't enough time to counteract the evening's macho drug-abuse "facts."

Had they been included on the panel, women would have first challenged Mr. Koppel's ridiculously low estimate of the number of people illicit drugs kill each year. He said it's between 5,000 and 6,000. Since no agency counts the total number, it's hard to imagine where he came up with that figure.

The best estimate available is from 1980 — 30,000 drug-related deaths. It defies logic that drugs kill fewer people today than eight years ago.

Women would have also challenged the assertion many made that smoking is going down. While that's true, it's not the whole truth. Smoking is declining among college-educated people, but it's going up among young people, minorities and — you guessed it — women.

Women would have pointed out that the $2.4 billion the tobacco industry spends in advertising targets young people, minorities, and women. Can anyone doubt there's a relationship there? Does anyone think a legal cocaine industry wouldn't do the same thing?

Women would have laughed Hugh Downs off the podium. A legalization proponent, Mr. Downs said 13-year-olds can get illegal drugs anywhere, but no one serves or sells them alcohol, which is legal. Get real, Hugh. When was the last time you talked to a 13-year-old? Or the parent of a 13-year-old?

Hang around a convenience store or a supermarket any day after school. Watch the kids buy wine, beer and wine coolers, the latter shelved between bottled waters and soft drinks. Is it any wonder the Weekly Reader found that 79 percent of fourth, fifth and sixth graders do not know coolers contain alcohol?

Women would have pointed out that the alcohol industry spends $1.4 billion to market its products to kids. So effective is this effort that 8- to 12-year-olds recognize, and spell correctly, more brands of beer than U.S. presidents, according to a poll taken by the Center for Science in the Public Interest. Are we ready for the Spuds MacKenzie of crack?

Women would have also pointed out that alcohol is the leading cause of death among young people, a point no one made during the entire broadcast.

And that's really the point. Legalization proponents insisted that we look at the tobacco and alcohol model, but refused to look at it themselves.

These two industries spend more each year to sell their products than the total amount Congress spends to fight drugs. The most significant difference between legal and illegal drugs is that illegal drugs generate no profits to spend on advertising and marketing. It's what holds use down: 18 million marijuana users compared to 116 million alcohol users; 6 million cocaine users compared to 60 million tobacco users.

To proponents who argued that profits from newly legalized drugs would be used for education and rehabilitation, women would have said, "Who's zoomin' who?" Congress hasn't raised the excise tax on alcohol and cigarettes since 1951. Wonder why that is?

An article in the May/June issue of "Common Cause" details campaign contributions the alcohol industry made to defeat the most recent proposed excise tax increase. Women would have made all these points, but weren't given the chance.

Come on, Mr. Koppel, include women in the debate. Better still, since your polls show 90 percent of the American people oppose legalization, why not drop it altogether?

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FROM KING FEATURES SYNDICATE INC., 235 EAST 45TH STREET, NEW YORK, N.Y. 10017

FOR RELEASE WEEK OF JULY 18, 1988 (Col. 1)

RUSCHE — STRAIGHT TALK ON DRUGS

WHOSE SPEECH IS FREER?

BY SUE RUSCHE

A movement to ban the advertising and promotion of alcoholic beverages is gaining momentum in Congress.

The movement derives primarily from the feeling many have that the alcohol industry markets its products to children and teenagers, people too young to legally purchase or possess alcoholic beverages.

The symbol that has galvanized people, perhaps more than any other, is Spuds MacKenzie, Anheuser Busch's mascot for Budweiser beer. Spuds, a cute little dog with a black spot around one eye, is a "party animal" who has enormous appeal to children. Parents were offended when Spuds showed up in television commericals during the Olympics. Spuds' on-air message, "Know when to say when," seemed appropriate for adults but inappropriate and out-of-place at an event viewed mostly by children.

A California father created an antidote to Spuds ("Duds McGenzie") after his 3-year-old daughter told him that Spuds is "the dog who sells beer." Her explanation was triggered at a county fair where a character dressed as Spuds MacKenzie handed her a Spuds sticker, according to the Bulletin on Alcohol Policy, published by The Trauma Foundation at San Francisco General Hospital.

Participants of the regional White House Conference for a Drug-Free America in Jacksonville, Florida, were appalled by the Spuds paraphernalia they found in a shop across the street from the Conference. The shop featured soft, cuddly Spuds dolls, Spuds posters and Spuds t-shirts — in children's sizes.

Nonetheless, the alcohol industry claims its sales pitches are not directed to children. It also claims its ads are protected by the First Amendment.

An incident in Muscogee County, Georgia, suggests that the industry thinks its speech is the only speech the First Amendment protects. The Muscogee County School System contains about 50 schools. It used a portion of its federal drug-education money to hire Carolyn Ferguson, a former school guidance counselor, to work full time as its drug-free schools program coordinator.

One of the many projects Ms. Ferguson conceived and carried out was a poster contest for elementary and middle-school children. With the approval and backing of school officials, Ms. Ferguson negotiated a contract with an outdoor advertising firm to display the three winning posters — one each from grades three and four, five and six, and seven and eight — on billboards throughout Muscogee County.

The firm agreed to donate the space. The school system agreed to pay production costs. The posters were to be displayed for 30 days. Because alcohol-related accidents are the leading cause of death among young people, Ms. Ferguson asked the children to design posters that discourage underage youngsters from using alcohol at all.

Lisa Finch, 13, won the contest for seventh and eighth graders. Her poster says "Drinking is Like Shaking Hands With Death." To the right of the slogan is a can of beer, called "SudLight," shaking hands with a skeleton. Nearby is a tombstone with the inscription R.I.P. — Rest in Peace. Out of the beer can's top pops a dog that looks a lot like Spuds McKenzie.

The day after Lisa's poster went up on the billboards, the black spot around Spud's eye got larger, so large, in fact that Spuds himself was obliterated. Distressed by the use of Spuds' copyrighted image without permission, the local Budweiser distributor insisted that Lisa's posters come down.

Down they came, although the other prize winners stayed up for over a month.

So whose speech is freer? The alcohol industry's, which insists the First Amendment protects its right to market beer in a way that appeals to children? Or Lisa's, who simply tried to express what she'd learned from Spuds?

You be the judge.

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CITY OF BOSTON · MASSACHUSETTS

OFFICE OF THE MAYOR
RAYMOND L. FLYNN

September 29, 1988

The Honorable Charles Rangel, Chairman
Select Committee on Narcotics Abuse and Control
U.S. House of Representatives
Room H2-234
Annex 2
Washington, DC 20515

Dear Congressman Rangel:

First of all, congratulations on your success in securing House passage of the Anti-Drug Abuse Act of 1988. Your tremendous leadership in battling America's drug crisis is an inspiration to all of us.

I am pleased that you are holding a hearing today on the issue of legalization of drugs and I am particularly pleased that we agree that to do so would be one of the worst moves that we as public officials can make. The only real way to end the plague that drugs represent is by reducing the demand for them. Reducing the demand for drugs can only be achieved through education; particularly for young people, and treatment for all who seek it. We cannot and will not achieve such demand reduction merely by changing the drug dealer.

To this end, I would like to submit for the record a copy of remarks which I gave at a "Say No To Drugs" rally in Boston's Mattapan neighborhood. From talking to many parents and young people, it is clear to me that legalization of drugs is a concept which has little if any support in our community.

Again, thanks to you and to the members of your committee for fighting the good fight against America's number one public enemy -- drugs.

Sincerely,

Ray Flynn

Raymond L. Flynn
Mayor of Boston

Attachment

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CITY OF BOSTON · MASSACHUSETTS

OFFICE OF THE MAYOR
RAYMOND L. FLYNN

NO SURRENDER IN THE WAR AGAINST DRUGS

A STATEMENT BY MAYOR RAYMOND L. FLYNN
IN OPPOSITION TO THE LEGALIZATION OF DRUGS
MADE IN CONJUNCTION WITH
THE MATTAPAN "SAY NO TO DRUGS" RALLY

MAY 28, 1988

In no uncertain terms, our nation is today engaged in a war with drugs. It's a war being waged with increasing intensity and violence on two fronts: at our borders and on the streets of our cities. It's a war, quite frankly, which, at present, our nation is losing.

The casualties of the war with drugs are measured in the same terms as other wars: lost lives, shattered families, ruined communities. As always, a number of the victims are innocent, many of them children who will never see adulthood. Others are the brave men and women at the front lines of the war: local, state and federal law enforcement personnel who are often outmanned and outgunned by well-financed armies of international drug dealers and local hit-men.

As with any war going badly, questions arise as to the level of commitment made to winning the war and the correctness of the strategy employed. Surrender, while always an option, is usually reserved until all others have failed and the outcome appears inevitable. For Americans, regardless of the enemy or the odds, surrender has always been an anathema to our spirit and determination.

In the war against drugs, our nation's strategy has been, to say the least, confusing. While the rhetoric from Washington has been consistently tough, a paucity of funding has limited our abilities to fight drugs on both fronts. Further, unholy alliances with such renowned drug dealers as Noreiga of Panama and Lon Vinh of Laos have cast serious doubt on our actual commitment to winning the war. This confusion, and the seemingly relentless flow of drugs from Latin America, Asia and elsewhere, have led some to call for surrender by legalizing the enemy itself -- drugs.

While not a new idea, the legalization of drugs is currently being proposed as a "solution" to America's drug problem. It is a proposal which raises more questions than it does answers, questions such as Which drugs should be made legal? Who will be permitted to buy them? And where will they be sold? If one believes, as I do, that drugs -- under any conditions -- are bad for people, then there are no acceptable answers to these and the myriad of other questions raised by the legalization idea.

Those who favor the legalization of drugs, for the most part, do so in the sincere belief that such a step would help reduce the flow of drugs coming into the country. With Uncle Sam as the dealer, they say, there will be no market for the international drug cartels, organized crime and whoever else is presently responsible for the thousands of tons of drugs crossing the borders each year. The question of who would supply Uncle Sam aside, the legalization proponents may be right on this point.

Where they're wrong, however, is in the belief that legalizing drugs will reduce the problem of drugs. Virtually every expert in the field agrees that the only real way to end the plague that drugs represent is by reducing the demand for them, i.e., people's appetite for drugs. Reducing the demand for drugs can only be achieved through: (1) educational programs aimed at preventing people -- especially children -- from first becoming involved with drugs, and (2) comprehensive treatment programs to help people with problems become drug-free. We can't and won't achieve such demand-reduction merely by changing the drug dealer.

Legalizing drugs will not only make it easier for more people to obtain them, it will also encourage the use and abuse of drugs by giving them society's stamp of approval. Given the considerable physical and mental health problems associated with almost all drugs, such a course would represent public policy of a most irresponsible form. One need only look at the ruined lives of junkies living on street corners, or athletes who have lost everything to cocaine addictions, or kids who have dropped out of school because they're hooked on pot or angel dust, to realize that making drugs legal is not the solution.

While everyone has an opinion on how to win the war against drugs, what's really needed is a comprehensive approach to addressing the numerous and different aspects of the problem. Such an approach should include the following steps:

One, a clear and consistent commitment to stopping drugs from entering our border. This will require substantially increased funding of federal drug enforcement efforts, the judicious use of the military, economic aid as a carrot to induce drug-producing countries to stop production, and the denial of aid to those who refuse.

Two, increased federal and state funding of local drug law enforcement efforts. This will enable local police departments to expand, train and better equip anti-drug units and patrols in high-crime areas.

Three, a variety of judicial reforms, including higher bail and stiffer sentences for drug criminals, and more judges and courtrooms to expedite the prosecution of drug cases. These changes are essential to reinforcing the message that drugs are wrong and that serious consequences will result from involvement with them.

Four, a multi-dimensional commitment to preventing children from becoming first becoming involved with drugs. One dimension is education -- beginning in elementary grades and continuing through high school -- about the dangers and consequences of drug use and abuse. Such instruction should also be made a part of afterschool and evening activities at neighborhood recreational and church centers. Drug education should also be incorporated into summer jobs programs for youth.

Five, increased federal and state funding for drug abuse treatment programs. Programs should be comprehensive in nature, including medical, personal and job counselling, and should be designed to address addictions to varying forms of drugs, as well as multiple-drug addictions

In the end, our nation's war against drugs will only be won by eliminating the social and economic miseries which lead individuals to drug abuse. What we need to achieve this goal are substantial "up-front" investments in education, health care, recreation and family programs, and reinvestments in urban neighborhoods to replace drugs with hope, opportunities and incentives to live drug-free. Until then, we need vigorous efforts in drug law enforcement, treatment and prevention. What we don't need to do is surrender to the problem by legalizing drugs.

5514 Roosevelt St.
Bethesda, Md. 20817
October 1, 1988

Hon. Charles B. Rangel
Chairman, Select Committee on Narcotics
2330 Rayburn House Office Bldg
Washington, D.C. 20515
Att: M. Kelly

My dear Congressman Rangel,

I wish to commend you for holding the informative hearings dealing with the legalization of drugs. The drug-abuse problem is a most pressing issue and light is greatly needed. These hearings made a real contribution

I noted the sharp differences of opinion as to the results of the Netherlands drug-policy. Prof Ruter of the University of Amsterdam, an authority on the Dutch drug policy, recently delivered a lecture on this subject. I believe this lecture will help clarify this point - of supreme importance - and therefore respectfully request its inclusion in the record of your hearings.

I shall appreciate receiving a copy of the full record of these hearings.

Respectfully,

P.S. As a newspaper columnist I am writing a series of articles on this subject.

THE DRUG POLICY FORUM

THE PRAGMATIC DUTCH APPROACH TO DRUG CONTROL: DOES IT WORK ?

Lecture held by Prof. Dr. Frits Rüter
University of Amsterdam, The Netherlands

on Wednesday May 25, 1988, 4:00 p.m.
Room B369, Rayburn House Office Building, Capitol Hill
Washington, D.C.

Sponsored By

The Drug Policy Foundation
Suite 400
4801 Massachusetts Avenue, N.W.
Washington, D.C. 20016
(202) 895-1634

THE PRAGMATIC DUTCH APPROACH TO DRUG CONTROL: DOES IT WORK?

Ladies and Gentlemen,

Let me start by quoting someone whose views are far more interesting and important than mine:

Basis of Dutch Policy

> "The protection of health and social well-being in general and the improvement of the health of those who are already addicted must be our primary aim. We always bear in mind that the drug abuse problem is basically and principally a matter of health and social well-being. It is not, in our view, primarily a problem of police and criminal justice.
> ... We are fully aware of the necessity to prevent as much as possible a situation in which more harm is caused by criminal proceedings than by the use of the substance itself."
>
> "We give high priority to services directed primarily at improving the health and social functioning of the addict, without necessarily ending addiction, because a lot of addicts are not, or not yet, capable of kicking the habit."

These quotations are not from a pamphlet of Libertarians or even from - what the British call - the lunatic left. They are from the speech delivered last year to the U.N. Conference on Drug Abuse and Illicit Trafficking by the Dutch Minister of Justice, a member of a conservative government, belonging to the traditional right-of-center party whose members include our captains of industry, bankers, judges and conservative professors like myself. This is the voice of the Dutch establishment.

The Minister's statement reflects the basis of the policy now pursued for more than 15 years by successive Dutch ministers of justice and Ministers of health, and supported by a broad majority in Parliament. As such it reflects
* the deeply felt concern of the Dutch people and government about the use of dangerous drugs and the level of drug-related crime,
* the limited possibilities, financial, legal and practical, for restraining effectively trafficking and the use of illicit drugs,
* our international obligations, and last but not least
* our humanitarian and moral obligations to minimize the damage to the society as a whole and the harm to the addicted individual.

Dutch policy pragmatic, not liberal

The biggest mistake one could make - and some members of the U.S. House of Representatives, visiting Holland in August 1987 appear to have made that mistake - is to regard this policy as the fruits of an overpermissive society. The Dutch policy on drugs is not a "laissez faire" policy, nor is it a liberal or lenient one.

It is, in American eyes, perhaps strange and unorthodox. But it is, above all, pragmatic and undogmatic. It is a fairly coherent, multi-disciplinary policy which attaches a high priority to the cost-benefit ratio.

This is perhaps the right moment to stress that I have not come to this country to recommend the Dutch drug policy as the perfect approach to the drug problem for all nations. No two societies are the same. What works well in Holland might be a disaster in your country - and vice versa. It is normal that countries tackle their problems in different ways. And there are good reasons to do so. Criminal law and the level of law enforcement are very much influenced by national tradition and the social and cultural structure of each society.

Astonishment at War on Drugs

On the other hand, I have to confess to some astonishment at the American handling of this problem. In my country the American nation is renowned, indeed almost notorious for its veneration for a business-like value-for-money approach to almost every problem of life. At the same time, it is admired for its high standard of constitutional freedom and its willingness to support its European friends in keeping or regaining their independence and civil liberties. It is to you, that we owe our freedom. In World War Two you liberated us from the Germans, today you protect us against the dangers from the East.

Your present War on Drugs and your pressure on foreign nations to join you in that battle does not fit easily into this traditional picture of your country. I have, however, no intimate knowledge of the American social and cultural setting and I am not familiar with the power structures in your country. Perhaps that is why I keep asking myself how it is possible that you handle the problem of drug abuse in such an unbusinesslike way. Any company that ran its affairs like that would have gone bankrupt long ago. And why it is that the American War on Drugs gives us the impression of a fatal marriage between Iranian fundamentalism and Communist economics. Is it because the American nation occasionally tends to choose the wrong allies ? Why are you embarking on a policy that leans so much on an ally like law enforcement which is by definition weak and inadequate ? And why are you not using the forces, which made the U.S. the biggest and most successful industrial nation in the world ? I am referring of course to the moral strength of the American people in general and of the American family in particular and the advantages of your capitalist system ?

Before you tell me that this clearly shows that I understand as little about the U.S. as you do about Holland, I shall quickly switch back to the subject of this lecture: the Dutch policy on drugs.

Approach of the Problem

Does it work ? And what exactly is this policy, in other words, how does it work ? .

I shall deal with these questions in the order I have indicated, since I hope that the results will sufficiently impress you to wish to learn more about our procedure.

But first of all, a word of warning. I do not regard myself as an expert on drugs. I am not a doctor, sociologist, psychologist or the like. Although marihuana is sold in a so-called coffee shop just around the corner from my Criminal Law Institute and hard drugs on the bridge across the canal on which the Institute is situated, I have never used or even seen soft or hard drugs. Because I am just an ordinary Dutch citizen, you can be sure that I will keep it that way. If I am an expert at all, I am an expert in the field of criminal law and law enforcement. Not, I hasten to add, because of any unfortunate personal experience. Although I and my family have lived and worked in the centre of Amsterdam for almost 30 years, we have never been the victim of any drug-related crime. My expertise is based on a combination of academic study, good advice from other experts and professional experience gained as a judge of Amsterdam Criminal Court and Chairman of the Police Complaints Board of the City of Amsterdam. I will, therefore, approach the problem not from the angle of narcotic drugs but from the angle of the criminal law and as someone who considers the use of dangerous drugs to be one of the many forms of undesirable behaviour in our society.

Let us now move on to the first question:

Does it work ?

in other words, is Dutch policy successful ? As always, the answer depends on your objective. Of course we all would like not a single drug to be used any more by anyone. But that is, at least at present, not a very realistic objective. In this respect I quote again the Dutch Minister of Justice:

> "One may have a high standard of morals and ethics about the banishment of all drug use. But whatever governments may wish or do, the reality is that not all young people- obviously - are deterred by the threat of punishment or health hazards and that our present efforts ... cannot keep thousands of them from using drugs".

If, however, given this reality, your present objective is to reduce the use of drugs, to bring down the number of new users to the drugscene, to minimize the damage to society, to keep the drug users alive, to let them mature out and to promote social rehabilitation not only in the after-care stage but also during treatment as an inseparable part of that treatment, the answer is different. If that is your objective and you would ask me whether the Dutch policy is successful, the answer is simple: yes, it is. Or, to put it rather more modestly: it is less unsuccessful than the drug policies of at least some other modern Western societies, including, perhaps, the U.S.

Figures and Facts

I will present to you the best possible estimates concerning drug use in the Netherlands, coming from reliable sources. However, as we all know such estimates are never fully accurate although the Dutch might be in a somewhat better position than many other countries, because the Dutch drug users are generally not underground and most addicts have been registered.

As far as cannabis [1]) is concerned, the number of new users has decreased shortly after the government decided on the decriminalisation of cannabis in 1976. Today about 4% of the Dutch young people between the ages of 10 and 18 years admit to ever having used cannabis (lifetime prevalence). But over 55% of them stopped using it before their 19th birthday [2]). The estimated number of [redacted] addicts has stabilised in recent years at between 15,000 and 20,000. That is 0.14% of the 14 million people living in Holland [3]). The average age of the addicts is increasing during the last 5 years. Experts infer from this fact that the number of addicts is slowly decreasing. The use of Cocaine has been growing very slowly. But in Amsterdam the number of new users has hardly been growing since 1982. It has remained fashionable only in a very limited part of society. The use itself normally does not provide serious social problems, as most cocaine users are quite well integrated in society and manage to live with their habit. The use of free base cocaine is a rarity. Ready made free base cocaine ("crack") has not been spotted in Holland. The use of amphetamines and LSD has always been exceptionally low. There have been no reports of the use of solvent or of new types of illicit drugs. The needle exchange program, providing free clean needles to intravenous drug users, which has operated on a large scale for many years, may be responsible for the fact that the number of AIDS-patients that are addicts is one of the lowest in the western world [4]). Because the possession of hard or soft drugs is not subject to prosecution and punishment although it is legally still a criminal offence, the users are not driven underground. Moreover, it is the official policy of the Dutch government to provide different forms of aid, which are not primarily intended to end addiction as such but to improve the addicts' physical well-being and help him to function in society, the inability of giving up drug use being accepted as a fact for the time being. Obviously the long-term objective is to help addicts lead a drug free life. But failure to provide medical and social aid would be worse as it would simply increase the risk to the individual and society. This kind of assistance may take the form of field work, initial reception, the supply of substitute drugs like methadone, material support and social rehabilitation support. This policy is successful. The majority of addicts have, in one way or another, contact with medical and social services. And generally they are in relatively good health; the death rate among addicts is around 0.5%, which is quite low compared with most other countries. Some of the addicts are members of so called Junky Unions. They thus have a means of making their views known to all kinds of government officials, which is not a bad thing if you are in need of an effective drug policy. Drug-related crime is still a matter of grave concern, both to the general public and to the government. But it is mostly nonviolent property crime. And the crime rate in Holland has not risen since 1984. In Amsterdam, the city in which the majority of drug users live, it even dropped last year. The drug use in Amsterdam is of course higher than in the smaller towns and the rural areas of Holland. Nevertheless it is not only lower than the use in New York or Washington but even lower than the use in the U.S. taken as a whole [5]). And the graphics on page 17 - 20 show, that the development of drug use in Amsterdam during the last decade has been anything but dramatic.

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[1] i.e. Harijuana and hashish

[2] See table 1, p. 15.

[3] See table 2, p. 15.

[4] See table 3, p. 15.

Misinterpretations

"That can't be true. I was in Amsterdam myself. I saw a number of "coffee shops" where cannabis was sold and I saw people dealing in hard drugs quite openly."
This is the usual reaction of foreigners, confronted with the figures and facts I have just mentioned. They make the mistake, as we all do when we are abroad, of judging foreign countries, societies and their social phenomena by our own, national standards. For visitors from countries, where drug users are underground, the visibility of the drug problem in Holland is shocking. If this can happen in public, what must go on in secret ? The answer is quite simple: not very much. Of course, the big traffickers are underground as the police are chasing them, but the small dealers and the users are generally not. There is no need for them to be, because they are not the primary target of the law enforcement agencies. And there is no strong social pressure from the public to go underground. The Dutch do not hide the problems of their society. Not only because they do not want them to get out of control, but mainly because Holland is a small, very old and stable democracy, in which we - the people - decide how we should solve our problems. And you cannot solve them by making them a taboo. So we tend to let our problems come to the surface and discuss them nationwide. Although this is good for our society, it does have the disadvantage that it occasionally gives Holland bad international publicity.

There is, as I said, no need for users and small dealers to go underground, because they are not the primary target of the law enforcement agencies. This brings us to the role of law enforcement in the fight against illicit drugs and to my second question:

How does the Dutch drug control policy work ?

One aspect of Holland which strikes most foreigners is the low level of law enforcement, both in general and in so far as illicit drugs are concerned. Nonetheless, both our countries started from the same point: the international drug treaties concluded at the beginning of this century.

Legislation

The first criminal legislation on drugs was introduced in Holland as early as 1919. Neither this Act nor the 1928 Act which replaced it and remained virtually unchanged until 1976 was introduced, however, in response to a drug problem in Holland. Indeed, until 1965 no such problem was evident. The illegal use of opium was virtually restricted to the Chinese community. As long as the drug was restricted to this community, no action of any note was taken. Until 1966 the number of convictions averaged 23 a year, which is around 1% of the present figure. Originally, the maximum sentence was 1 year's imprisonment. Until the sixties political interest was extremely limited. The reason for this legislation on drugs must therefore be sought in the drug treaties, instigated by the U.S., and not in our own problems.

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[5] see the table on p. 16 and compare it with the National Household Surveys on Drug Abuse of the U.S. National Institute of Drug Abuse.

In 1961 the Single Convention expanded the number of illicit drugs and laid great emphasis on law enforcement. When Holland was shortly afterwards confronted with a substantial increase in the use of marihuana and later of hard drugs, we leaned, at first, very much on Law Enforcement and the police and the judiciary dealt severely with drug users. But soon it became clear that this approach was essentially incompatible with the country's traditional way of combating undesirable behaviour.

Role of Criminal Law

In Holland the role of the criminal law is a relatively minor one. The Dutch prefer a policy of encirclement, adaption, integration and normalisation, rather than a policy of social exclusion through criminalisation, punishment and stigmatisation. Furthermore, they have no exaggerated expectations of law enforcement. And finally, the Dutch see the criminal law less an instrument for expressing moral values and more as an instrument of social control, whose results must be assessed from case to case.

When it was faced with the task of fighting the increasing drug use, the Dutch government became trapped between on the one hand the international conventions on narcotic drugs and the pressure exerted by states where criminal law plays a much greater role and on the other the traditional Dutch views on the limited task, role and scope of criminal law. Between these conflicting premises, the Dutch government steered a middle course trying to reconcile its international commitments (prohibition, law enforcement) with the traditional national commitment towards institutional plurality and social experimentalism.

The 1976 amendment legislation and in particular the guidelines for the prosecution bear the traces of this policy. This legislation contained a clear signal, namely that Holland was prepared to bring its legislation on hard drugs into line with the international trend. The maximum penalties were increased considerably. Despite pleas from various quarters for the legalisation of marihuana, this did not come about, the government making express reference to the Single Convention. However, the maximum penalties for marihuana were set at a lower level than those for hard drugs. And in 1985, a whole series of preparatory acts were made criminal offences in order to combat international drugtrafficking.

Criminal Justice Policy

As far as its legislation is concerned, Holland is undoubtedly in line with its international commitments and to a large extent with the international trend as well. But legislation is not necessarily the same as the criminal justice policy which is in fact implemented. The Dutch criminal law provides considerable latitude for such a policy, because, by virtue of the so-called "expediency principle", the Public Prosecutions Department is empowered to refrain from bringing criminal proceedings if that is in the public interest. It is a matter of policy whether the Prosecution will act and, if so, what it will do. This policy is laid down in so-called Guidelines for Investigation and Prosecution. To know what the law in action is like, you need to know what these Guidelines say.

Guidelines

In 1976 the Minister of Justice issued guidelines for the investigation and prosecution of drug offences. In these guidelines the Dutch government translated the international trend into the less prohibitionist, less retributive and less punitive criminal justice policy traditionally pursued by the Dutch, in an attempt to reconcile its international obligations with its national commitments and national political options.

In line with the international trend, the guidelines give top priority to the investigation and prosecution of production, import, export and large scale traffickng. In such cases, prosecutions are brought and the sentences demanded by the Prosecution at the trial must as a rule exceed the statutory minimum by a number of years.

The guidelines specify a milder approach in the case of four categories:
a) users who deal in hard drugs in order to provide for their own needs or who are found in possession of more than a small quantity: in such cases the public prosecutor must demand a prison sentence, but is free to determine the length of the sentence to be demanded;
b) possession of a small quantity of hard drugs for personal consumption: no specific police investigation, no pre-trial detention and as a rule no prosecution.
c) dealing, possessing and producing a maximum of 30 grams of marihuana: no specific police investigation, no pre-trial detention and as a rule no prosecution.
d) sale of marihuana in small quantities by a reliable person in a youth centre (known as a house dealer): no prosecution unless the dealer trades provocatively or openly advertises his wares.

Today's Practice

From these guidelines evolved a practice which was summarised by the Minister of Justice nine years later, in 1985, as follows:

> "Hard drugs: criminal investigation and prosecution are directed against trafficking. No criminal proceedings against users."

Consequently no person is subject to imprisonment or prosecution solely because he or she uses drugs. Instead users are, in accordance with the government policy set out before, approached by organisations of a multi-functional network providing financial, social and medical assistance to addicts.

> "soft drugs: the small dealers and users are left undisturbed by the police."

In practice this means that the police do not interfere with marihuana sales in coffee shops, unless the dealers are selling

to persons under 16, selling large quantities or advertising. I give you two examples to illustrate the present situation:
(1) A coffee shop owner filed a complaint against the Amsterdam Police with the Police Complaints Board for raiding his shop although he had observed these rules. My colleagues and I held that the complaint was justified and the police admitted they had been wrong. (2) As from January of this year the Dutch Ministry of Finance is taxing the profits which the coffee shops make on soft drug sales.

Reasons

For many foreigners this is a somewhat confusing state of affairs: the law formally declares certain acts to be punishable but the law enforcement agencies do not prosecute them in practice. According to Dutch Penal Law, this is legal. But still you may ask, why the Dutch prosecute some crimes like murder and rape and yet leave others unpunished. The answer is that the Dutch have a pragmatic value-for-money approach. Otherwise we would not, as a small country, be able to run the biggest port in the world and have a number of well-known multinationals like Shell, Unilever and Philips. After defining their objective therefor, they take a close look at the means at their disposal to achieve that objective. The objective of Dutch drug policy is to restrict the risks of the use of dangerous narcotic drugs as effectively as possible. Is criminal law in that context an ally or an enemy ? Sometimes it is an enemy. Take for instance the cannabis situation in Holland before 1976.

Until then no legal distinction was made between marihuana and hard drugs. This meant that marihuana was forced into the criminal sphere in common with hard drugs and that it was sold in the same places and frequently by the same dealers. It was, in other words, fully integrated into the hard drugs scene. The Dutch Government decriminalised the possession and trading of small quantities of marihuana because it feared that the unintentional effect of law enforcement might be that marihuana would act as a stepping stone to hard drugs. This decriminalisation policy was intended to separate the markets for marihuana and hard drugs and to remove the sale and consumption of marihuana from the hard drugs scene.

Marihuana
Policy
successful

This policy was successful: the markets *were* separated and the overwhelming majority of marihuana users did *not* graduate to hard drugs. The experience of over 12 years has shown that - at least within this Dutch context - the gateway (or stepping stone) theory is not true. And this policy had another positive result: the number of new users has decreased shortly after the government decided on the decriminalisation of cannabis in 1976 despite the fact, that since then marihuana became more freely available in Holland [6]). This is even more remarkable when compared with the situation in West Germany, our neighbour, where the sale and possession of marihuana are a criminal offence and prosecutions are brought: the percentage of young Germans who admit to ever having used cannabis (lifetime prevalence) is approximately twice as high as in Holland.

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[6] See table 4, p. 15.

Law enforcement a suitable instrument for the fight against illicit drugs ?

This is, in a nutshell, the Dutch drug control policy and the way it works. You may like it or dislike it. It is true, we have not managed to attain a drug-free society. But what country has ? On the other hand, the low level of law enforcement has not - to say the least - resulted in a higher level of drug use than in other Western democracies. And even 12 years of decriminalisation of marihuana have not increased its use. And finally, we have managed to keep our drug users in relatively good health and to limit the number of addicts with AIDS.

Rethinking Criminal Law

In my view, the importance of Dutch drug policy and its results is that it encourages us to rethink the role of criminal law and law enforcement in coping with drug use. There is ample reason to do so. And this applies equally to the Dutch situation. Hence, although the role of law enforcement may - as the Dutch Minister of Justice put it - be only a "supportive" one, and less important than in many other countries, it is still a meaningful factor in the Dutch drug control policy. This seems to be connected above all with the fact that the general public considers that drug trafficking should carry heavy penalties.
But: this does not in itself mean that law enforcement is a suitable instrument for the fight against drug trafficking. Until now there has been no evidence of this. Is this due to an inadequate level of investigation and prosecution, to light sentences, to a lack of powers for the police or to deficient international cooperation ? Or is criminal law, instead, structurally unsuitable for the fight against drug trafficking ?

Allow me to end this lecture by stating my personal views on this question.

Law Enforcement unsuccessful

For nearly 30 years penal provisions and law enforcement have clearly proved unable to prevent a situation in which illicit drugs are sold on a large scale and are used by millions and millions of people all over the world.
I put it to you that this is not surprising because it follows from the very structure of the criminal law. And I also put it to you that law enforcement is not our ally in the fight against the use of drugs. These are my arguments:

Reasons

The goal of law enforcement is to prevent undesirable behaviour. We punish wrongdoers in the hope that they will not repeat their behaviour (individual deterrence) and that others in turn will be scared off (general deterrence). And we punish by way of retribution. The degree of retribution takes into account the extent of the criminal's guilt. We may not exceed the bounds of what is a well-deserved punishment, given these factors.

This rule of criminal law is common to all civilised nations. However, it is precisely this rule which creates the first structural weakness of the criminal law in its fight against illicit drugs. If one only uses illicit drugs, the perpetrator and victim are to a large extent one and the same person. There

Users

is therefore precious little reason for retribution or accordingly for punishment. If the punishment were to be substantially increased, this would not only violate the principle of a humane and just criminal law. Substantially heavier sentences have scarcely any extra deterrent effect because the threat of the criminal law does not have much impact on the lifestyle of the addict, who often is not allowed to do anything else but pursuing drug use in the margins of society.

Traffickers

Nowadays the criminal law concentrates on traffickers, imposing heavy sentences as retribution for unscrupulously earning money from the misfortunes of others. We have therefore made punishable an almost never-ending sequence of acts, such as cultivation, production, distribution, delivery, transport, importation and exportation. All of these acts would leave us completely unmoved if the drugs thus obtained were not consumed. The principle underlying this approach is the assumption that drug use cannot continue without supply. But this is true only if the supply of the drug itself or of its basic materials is completely cut off. This is where the criminal law fails miserably, despite extensive penal provisions, intensive law enforcement and severe penalties and becomes counterproductive.

Criminal Law must fail

And criminal law must fail because of two simple and well-established truths. First, demand creates supply and thus provides the impetus to do what, in the case of illicit drugs, the law prohibits. Second, never in the history of mankind has the criminal law succeeded in completely eliminating proscribed behaviour. Not even when the law was backed by almost universal public understanding and support. We all know that.
We have become accustomed to the idea that the criminal law can never prevent more than a given proportion of crime. Theft, rape and murder will always be with us. And yet no one argues that these acts should be decriminalised because the criminal law has failed to eliminate them entirely. We accept the deficient operation and limited success of the criminal law because the position that has been reached is the best one possible in the circumstances. But: things are different in the case of drug use because the deficient operation of the law takes us even further away from our goal.

What happens after all ? The trafficker sells drugs in order to make money. If his profits were to dry up or be exceeded by the costs he incurs, he would go out of business and drugs would no longer be supplied.

Seizure of drugs

In theory, his profits could dry up if it could be ensured that the drugs do not reach the customer. Naturally, the criminal law is not needed for this purpose. Any agency could confiscate illicit drugs. Yet it might be supposed that the law enforcement agencies with all their resources and powers, would have a great success rate in the seizure of drugs. This, however, is not true. A 10% seizure rate is the most optimistic estimate.

Costs passed on

The other course of action would be to allow the cost to rise so much that the traffickers have to work at a loss. This too cannot be effected through law enforcement. Of course, law enforcement measures push up the costs for the trafficker, but they have little effect because he simply passes the extra costs on to the consumers, who in turn pass them on to the general public. The latter are forced to finance the drugs market as the victims of theft, embezzlement, burglary, robbery and other drug-related crimes. So the price mechanism simply does not work.

Enormous Profits

The seizure of drugs and the arrest of traffickers have little effect because both drugs and traffickers are quickly replaced. The enormous profits ensure that there is never any shortage of recruits. Even worse when a young person can make 2,000 a day dealing, this influences the behaviour of his peer group much more strongly than any drug education program can possibly do.

Seizure of Profits

Seizure of the profits from the drug trade, which is at present the subject of international consultations and draft conventions can succeed only if there is worldwide solidarity. Unfortunately this is in short supply. I need only say "Switzerland", "The Bahamas" or "Panama" and you will know what I mean.

Law Enforcement not an Ally

So far we have seen that law enforcement is a weak highly overrated and grossly overpaid ally. That is, as we all know, dangerous enough when you are waging a war relying almost exclusively on that ally. But the situation is worse. When we take a second look, it becomes obvious that law enforcement is not an ally at all. The inevitably deficient operation and limited success of the criminal law transforms the drug trade into an entrepreneurs' paradise, creating and maintaining a black market that guarantees huge tax free profits, and stabilising the supply and price. Law enforcement does not, therefore, deter the trade. Instead it encourages drug trafficking at every possible level and it is indeed crucial to its survival. Law enforcement, therefore, is not an ally. It is a traitor.

Side effects

Before this audience, there is, I trust, no need to describe all the counterproductive and negative side-effects of law enforcement in this field in any detail.

Criminal Justice System in Peril

As a lawyer, however, I should like to draw your attention in particular to the risk that we may lose the criminal law as a means of social control in those cases in which it still does work (albeit not perfectly) and in which it is indispensable for a just and peacable democratic society.

By attempting to use the criminal law to attain the unattainable, we are burdening the criminal justice system with such problems that it can no longer satisfactorily discharge its role in limiting the other forms of crime. First of all, this is a quantitative problem. Our criminal justice system is being flooded by drugs cases. It is getting blocked up.

Quantitative Problem

It is estimated that the Dutch police spend half their time on investigating drug trafficking and drug-related crimes. Over 75% of the suspects taken into police custody in Amsterdam are connected in some way with drugs, and 70% of the persons remanded in custody by the examining magistrate are either drug traffickers or involved in drug-related crimes. In our prisons nearly 50 percent of the inmates are drug addicts. Even in the prisons, which are of course the most secure places in the criminal justice system, it has proved impossible to eradicate the possession and use of drugs. The other prisoners too are under pressure to use drugs and the prison officers are under pressure to help provide them. Hence there is a very real danger that the prison staff will be corrupted. And similar problems are evident outside the Netherlands. Almost everywhere in Europe we see overcrowded prisons.

I recognize that it is normal that some offences are given a higher priority than others in law enforcement. After all, no country has ever been able to provide sufficient money and manpower to enable its law enforcement system to deal with all offences. It has always been necessary to make choices and set priorities. But the devotion of huge resources over such long period to just one kind of offence inevitably means that other offences are neglected. As a consequence, there is tension and dissatisfaction both among the general public and in the police force itself. Slowly but surely, the police are losing the essential support of the public and even of part of their own organisation and of the politicians. A recent survey showed that 40% of the inhabitants of Amsterdam considered that the protection afforded by the police was insufficient. Not because the police pay too little attention to drug abuse but because they do too little to prevent bicycle theft, burglary, vandalism and hooliganism. These are all offences to which the general public accords a higher priority than drug abuse. And again this not a typically Dutch phenomenon either. In 1985 Harald Körner, a public prosecutor and well known expert on drugs in West Germany, noted a similar development in his country.

Quality seriously at risk

But in addition to this quantitative problem the quality of the criminal justice system is also seriously at risk. The decision to use the criminal law in the fight against undesirable behaviour is taken not because this is the easiest path but because we wish to conduct the fight in accordance with the rule of law. The value of the criminal law lies primarily not in its function of combating crime but in the requirement that this function should be fulfilled in accordance with the law. Because of the strong pressure to score, in other words to win the war on drugs, there is an increasing tendency to alter the order of priority: success becomes more important than observing the rules of law.

This is exceptionally dangerous for a democratic society. First, because private individuals no longer have any inducement to obey the law if law enforcement officers themselves ignore the law whenever it suits them. This harms rather than benefits crime prevention. Second, law enforcement organisations which decide to operate outside the bounds of the law when need arises are in fact out of control. Since they have lost their integrity, they are susceptible to widespread corruption. In this way they become a greater threat to a democratic society than the very evil they were trying to eradicate.

Fostering the Maffia

But this is not all. We are fostering an international maffia whose immense income, highly developed criminal organisation and far-flung interests (including interests in gambling, prostitution, firearms and the trade in women) are enabling it to extend its sphere of influence into legitimate business, into government circles and even into law enforcement agencies. According to police officials, quoted in Newsweek of last March 14, these organisations are superbly organized and can buy off anybody they want, including law enforcement officers. The very roots of our society are threatened by this corruption. If we wait much longer, we will no longer be able to rid ourselves of them.

I have not told you anything new. You know the facts, I know the facts and governments know the facts. And we would all act accordingly if we were prepared to handle the problems in an unemotional and professional way. But most of us, and in particular governments, do not like to make the choices, which are now needed [7]).

If there were no Law Enforcement

Suppose for a moment that the acts in question were not criminal and that law enforcement was consequently not involved. We would then have a situation in which there would be no black market, no monopoly, no tax-free profits and no reason for "pushing". The international maffia would see its profits from narcotics dry up overnight. Its economic potential and its corrupting influence on governments and in society at large would decline. Drug-related crime would as good as vanish. The number of prisoners would decrease and addiction in the prisons would no longer play such a significant role. Enormous resources would be released to fight drug use by other means and to combat other crimes. And the quality of criminal law as a legal instrument could be restored.

By continuing to apply the criminal law we are placing ourselves on the horns of a dilemma. We know the alarming counter-productive effects. But what we do not know is whether drug use would increase if the criminal law were to withdraw from the scene. On the other hand, the Dutch experience of dealing with marihuana over the last 13 years indicates that the situation might get not worse, but better without law enforcement. This is not as surprising as it may seem at first sight. First, because everyone who wants to use illicit drugs can get them even now, albeit illegally [8]). And second, because it is a severe underestimation of the moral stability of young people in general to believe that they will all use drugs the moment this would no longer be a criminal offence. But it is true: we shall never know this for certain until we try it. No government likes to take this kind of decision. But we will have to. The day cannot now be far away when an increasing number of states will be unable or unwilling to meet the costs of the negative effects of a drug policy dominated by law enforcement. In Holland for instance, members of the "Law Enforcement establishment" like judges and police chiefs advocate a gradual withdrawal of the criminal law from this field. And in some other European countries the possession of small quantities of hard or soft drugs for personal use is no longer a criminal offence.

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[7] "An absolute worthiness or fault approach has proved remarkably stable in some areas of criminal law (like drug addiction), when there is good reason to believe other approaches would be less costly were it not for the stark clarity of the tragic choices they would necessitate". Guido Calabresi and Philip Bobbitt, Tragic Choices - The conflicts society confronts in the allocation of tragically scarce resources. New York, 1978, p.75.

[8] For the availability of illicit drugs in the U.S. see: the National Narcotics Intelligence Consumers Committee Report on the supply of illicit drugs to the United States from foreign and domestic sources in 1985 and 1986.

A Black Friday for the Traffickers!

Mayor Ed Koch of New York City was quoted by Time Magazine some months ago as arguing in favour of massive military interdiction and saying that "the political aim of the drug traffickers is to make addicts of all of us". But even great men make mistakes. It's not a political but a financial aim. Hence, we should not fight them with the army or the police. The use of drugs is too serious to leave it to them. We should utilize those forces in our society, which have always been victorious in the past. I am refering to the forces of our capitalist system. What we need is a black Friday for the traffickers. The U.S. could bring this about by giving up its unhappy alliance with the criminal law. And why should not it ? Unless, of course, it has no confidence in the moral strength of the American People and Nation.

Table 1. The use of cannabis in Holland 1984
(School survey among 25,000 young people 10 - 18 yrs)

age group:	10 - 18	17 - 18
tried but no longer used	2.3%	5.6%
still using	1.9%	6.5%

└──> One per thousand used it daily

Table 2. Estimated number of hard drug addicts

Country	Maximum	% of total population
Holland	20,000	0.14 %
West Germany	109,000	0.19 %
Denmark	10,000	0.20 %
Italy	250,000	0.45 %

Table 3. Proportion of Aidspatients, that are addicts

Country	%
Holland	3 %
Great Britain	5 %
Western Germany	15 %
City of New York	17 %
Italy	20 %
Switzerland	35 %
Austria	45 %
Spain	50 %

Crucial

Table 4. The use of cannabis in Holland before and after its decriminalisation

age group	before (1976)	after (1985)
15 - 16 yrs	3 %	2 %
17 - 18 yrs	10 %	6.5 %

Drug prevalence in Amsterdam (1987)

Household survey (representative sample of 4202 respondents of 16 years and older)

	life time prevalence		last year prevalence		last month prevalence						
					total (month)		on presciption		without prescr.		
drug	n	%	n	%	n	%	n	%	n	%	N
tobacco	3091	73.6	2147	51.1	1994	47.5	-	-	-	-	4200
alcohol	3733	89.0	3373	80.4	3081	73.5	-	-	-	-	4194
hypnotics	863	20.6	487	11.6	357	8.5	306	7.3	58	1.4	4196
sedatives	965	23.0	467	11.1	319	7.6	246	5.9	77	1.8	4198
cannabis	988	23.6	403	9.6	241	5.7	-	-	-	-	4194
cocaine	245	5.8	68	1.6	27	0.6	-	-	-	-	4195
amfetamines	192	4.6	27	0.6	13	0.3	-	-	-	-	4190
opiates	400	9.6	105	2.5	49	1.2	29	0.7	13	0.3	4187
(heroin)	-	-	14	0.3	11	0.3	0	0.0	7	0.2	4187
lsd	118	2.8	5	0.1	1	0.0	-	-	-	-	4194
other hallucinogens	102	2.4	17	0.4	4	0.1	-	-	-	-	4194
inhalants	43	1.0	10	0.2	6	0.1	-	-	-	-	4191

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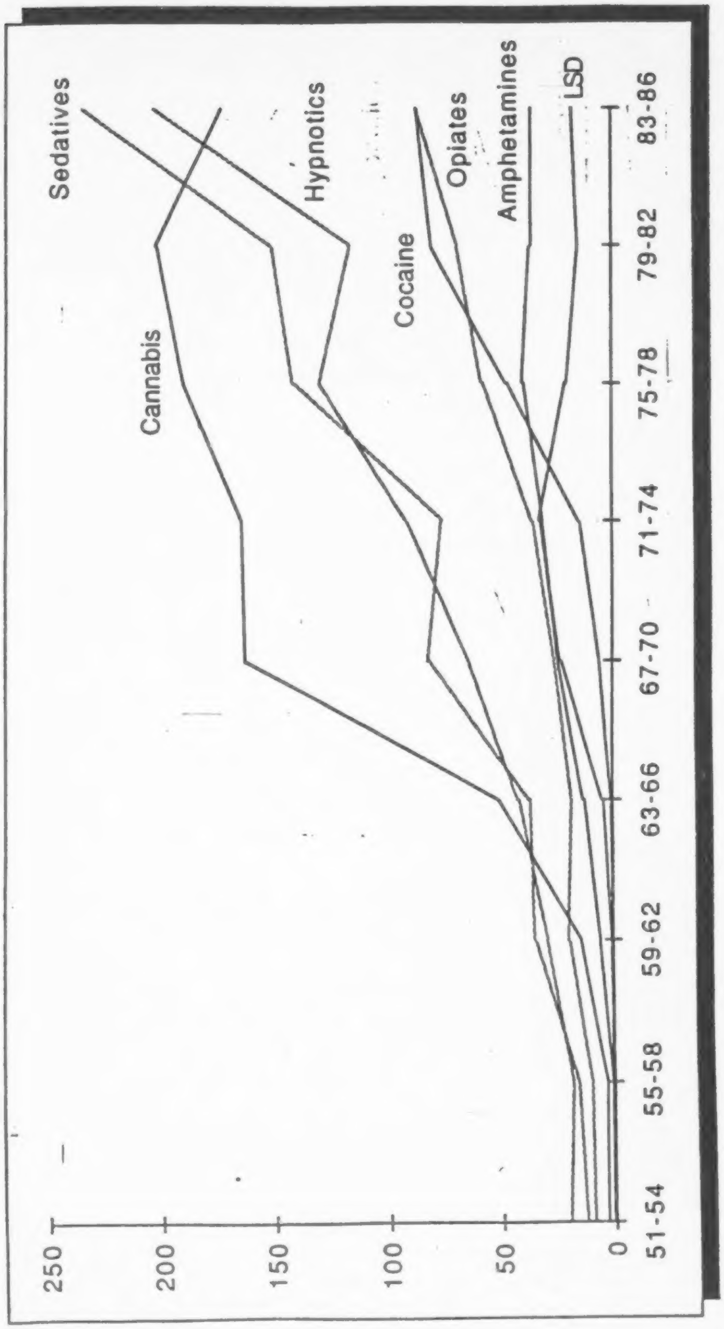
The opiates contain a.o. opium, morfin, heroin, codein, palfium, methadone.

Codein is largely used on prescription, heroin without prescription and methadone both.

Source: Musterd,S:, P.Sandwijk & I.Westerterp: "Drug use in Amsterdam" (1988, forthcoming)
Department of Social Geografy, University of Amsterdam

raphic: Year of first use of several drugs in Amsterdam

lousehold survey (representative sample of 4202 respondents of 16 years and older)



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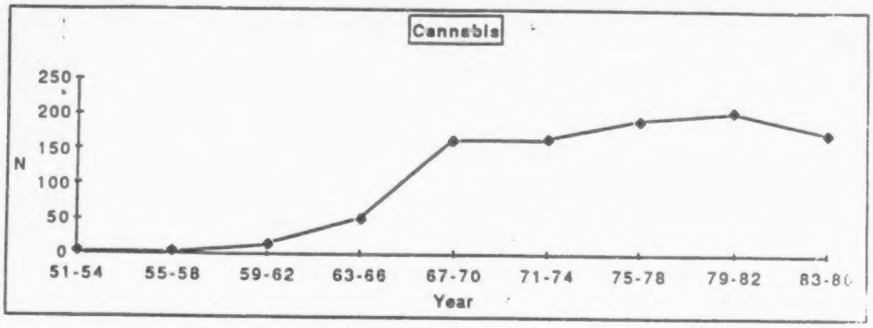
Graphics: Year of first use of several drugs in Amsterdam

Household survey (sample of 4202 respondents of 16 years and older)

N.B. Heroin: only those respondents who still used heroin in the last year before the interview (1987)



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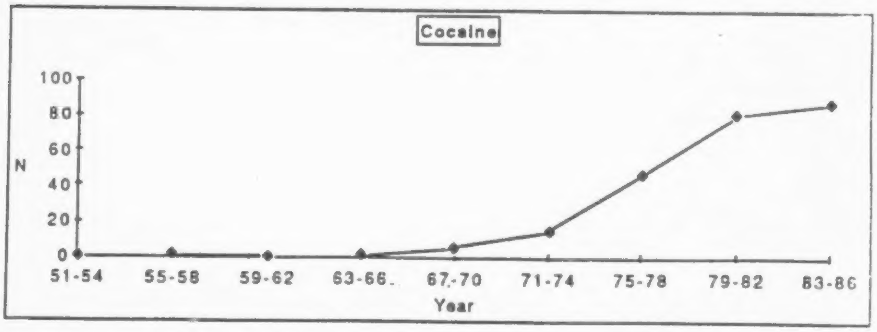

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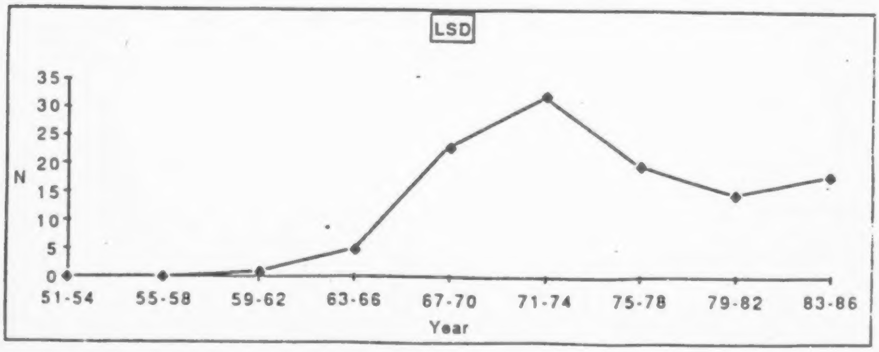

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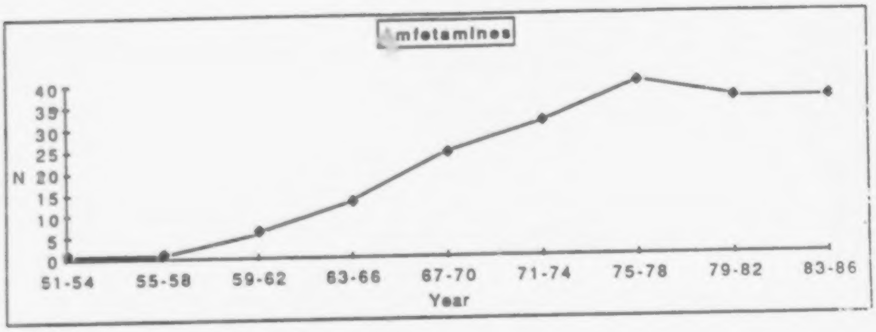

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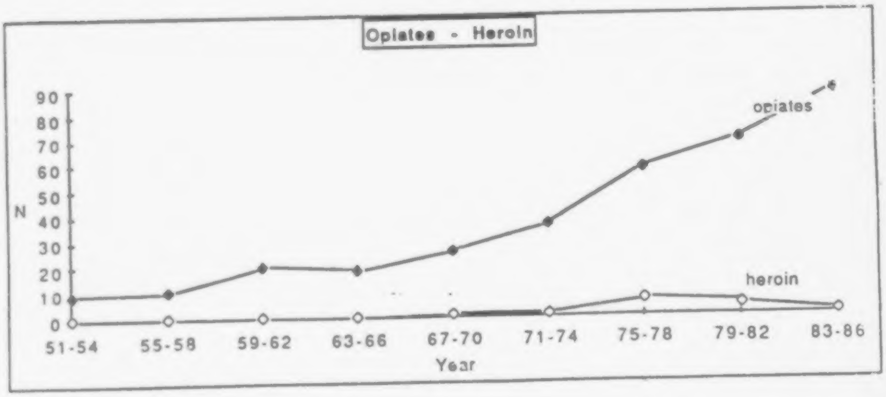

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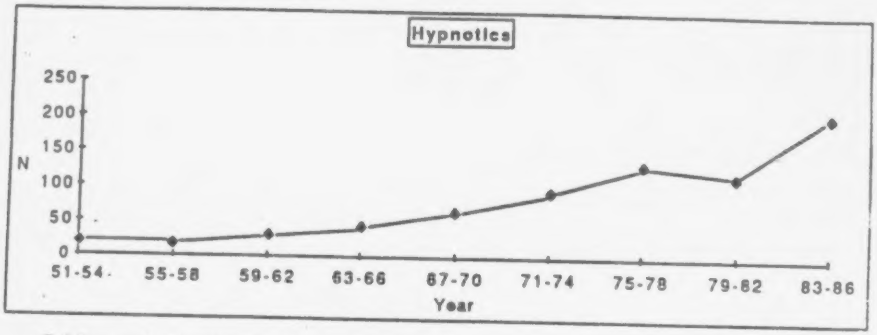

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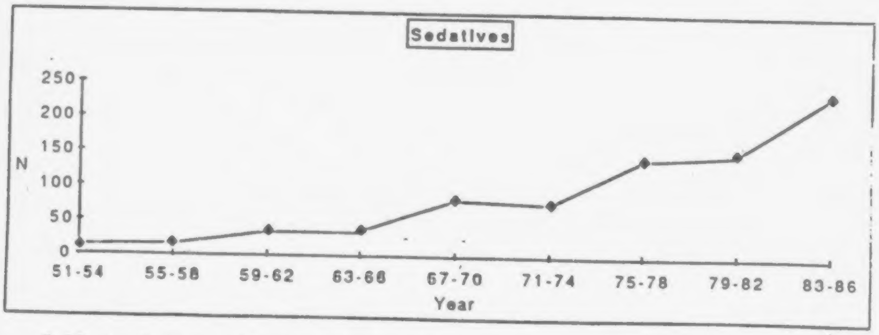

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Source: Musterd,S., P.Sandwijk & I.Westerterp: "Drug use in Amsterdam" (1988, forthcoming) Department of Social Geografy, University of Amsterdam

I am greatly indebted to
Peter Cohen, Director of Drugs Research, City of Amsterdam
Eddy Engelsman, Ministry of Health, The Hague
Arnold Heertje, Professor of Economics, University of Amsterdam
Ed. Leuw, researcher, Scientific Research and Documentation Centre, Ministry of Justice, The Hague
S. Musterd, P. Sandwijk and I. Westerterp, Department of Social Geography, University of Amsterdam
Henk Jan van Vliet, former researcher, National Federation for Alcohol and Drugs
for information, the use of their published and unpublished material and their expert advice.

Frits Rüter, born 1938, graduated as a lawyer at the University of Amsterdam in 1962. From 1962 to 1966 he studied at the Max Planck Institute for foreign and international criminal law in Freiburg im Breisgau/West Germany.
Ph.D. Amsterdam 1973.
Since 1973 he has been a senior professor of criminal law at the University of Amsterdam and director of its criminal law institute.
He is a deputy judge at Amsterdam Criminal Court, a member of the Benelux Commission for the Unification of the Law, chairman of the Police Complaints Board of the City of Amsterdam and a member of the International Advisory Board for the publication of the Nuremberg Trials. As official representative of Amnesty International/London he has attended several trials and taken part in various investigative missions, mainly in Eastern Europe.

Publications: "The Prosecution and Trial of War Crimes and Crimes against Humanity" (1973); "Justiz und NS-Verbrechen", a complete collection of West German war crimes trials (22 vols); The Tokyo Judgement (2 vols); books on Dutch criminal law and various articles on Dutch criminal procedure, international cooperation in penal matters, drugs and the criminal law etc.

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NATIONAL ORGANIZATION FOR THE REFORM OF MARIJUANA LAWS

NORML

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October 13, 1988

Hon. Charles Rangel
Chairman
House Select Committee
on Narcotics Abuse and Control
Room H2-234. House Office Bldg Annex 2
Washington, D.C. 20009

Dear Congressman Rangel:

Thank you once again for the opportunity you provided NORML to testify before your committee September 29th and 30th. Would you please include these final two comments for the record?

1) Caution should be exercised in comparing survey data about Alaskan drug use and drug use in the other 49 states because of marijuana's legality under Alaska state law. According to Bernard Segal, Ph. D., as part of the Alaska Drug Use Survey published by the Center for Alcohol and Addiction Studies in 1983, "the National Survey conducted face-to-face interviews while our procedure involved anonymous responses to questionnaires. It may be that when youth are selected from a general population and interviewed, the reports of prevalence of drug use may be more guarded than when responding anonymously to a survey." This point was further clarified in testimony provided by Dr. Segal before the Alaska House Committee on Health, Education and Social Services on April 14th, 1988. Dr. Segal indicated that problems with under-reporting exist for the NIDA-sponsored surveys of drug use in the continental 48 states because of the illegality of the activity questioned.

In short, it is hard to determine if the Alaska data indicates a higher prevalence of marijuana use in Alaska, or an underreporting of use in the rest of the country. The NIDA Household survey only accounts for the consumption of about 4700 metric tons of marijuana whereas NNICC estimates that up to 12,000 metric tons of marijuana was available in the U.S. during 1987.

2) Sue Rusche testified that marijuana use in the United States increased dramatically after decriminalization laws were passed during the 1970's. Only 11 states enacted decriminalization legislation, whereas the data Ms. Rusche cited had to do with marijuana use nationwide. Surveys did show marijuana use increasing during the late 1970's, yet it increased at a slower rate in decriminalized states than nationwide.

Sincerely,

Jon B. Gettman
National Director

STENY H. HOYER
5TH DISTRICT, MARYLAND

DEPUTY WHIP

DEMOCRATIC STEERING
AND POLICY COMMITTEE

CHAIRMAN
COMMISSION ON SECURITY AND
COOPERATION IN EUROPE

Congress of the United States
House of Representatives
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October 24, 1988

The Honorable Charles B. Rangel
Chairman
Select Committee on Narcotics Abuse and Control
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman,

I understand that during the hearing your Committee held on the question of drug legalization, you stated you would hold the record open for me to submit a statement. I appreciate your consideration in that regard and would like to submit the enclosed statement.

Thanking you again and with warmest personal regards, I am

Sincerely yours,

STENY H. HOYER

Enclosure

Statement of the Honorable Steny H. Hoyer
Select Committee on Narcotics Abuse and Control
September 29, 1988

Mr. Chairman, thank you for the opportunity to add my remarks to the record of today's hearing. I would like to commend you for moving forward with the idea to hold hearings on the issue of drug legalization. As the Chairman of the Select Committee on Narcotics Abuse and Control, you have been a leader in the Congress in formulating and advocating realistic, humane and effective policies to fight drug abuse in our nation. The question of legalization has increasingly become a subject of debate, discussion and commentary. It is appropriate that the Congress, and particularly this well respected Select Committee under your leadership, examine the issue and make its contribution to the debate.

I would also like to commend the Mayor of Baltimore, Kurt Schmoke, for bringing this issue to the attention of the Congress and the nation. He has shown great foresight, political courage and leadership in addressing the issue of drug abuse, drug-related crimes and legalization in a forthright, honest and open-minded fashion. He has made an important contribution to the effort to end drug drug use and abuse in our nation.

I am opposed to the use of any substances which undermine the health and mental acuity of individuals, be they illegal substances or legal substances such as alcohol or cigarettes.

The latter two substances cause more deaths and illness than illegal substances. In 1983, alcohol abuse was responsible for 100,000 deaths and in 1984, 320,000 deaths were attributed to tobacco consumption. I think we need to urge all young people and others of any age not to use substances which will undermine their ability to utilize their talents to the fullest and to live long, happy and productive lives.

While I am not in favor of the legalization of drugs, I do support examining and discussing the question of legalization and surrounding issues. Clearly, our current efforts are not being successful and it is counter-productive to ignore the realties of the situation and to fail to examine our alternatives. The economic and social costs of illegal drug trafficking and addiction to this country are high and rising. Increased health care costs, lost productivity and related crime and violence costs our nation over $100 billion annually.

Seventy percent of the violent crimes committed in the Washington, D.C. metropolitan area are drug related. One million dollars in raw materials will earn a drug dealer $5 billion dollars in revenue. Fifty million Americans have tried marijuana and there Are 25 million Americans who are regular users of marijuana. There are 30 million occasional users of cocaine. The United States has one of the highest rates of drug use among the world's industrialized nations. When one considers those statistices, we can see how the illegal drug industry in the United States has become a $150 billion industry. It is not difficult to make a correlation between the violence associated with drug trafficking, the profits involved in illegal drug trade and the crime rate. While I have strongly supported enforcement and interdiction efforts, and will continue to do so, it is clear that a large portion of the drug problem in this country is related to demand. Until a majority of the public decides that the use of drugs is objectionable, and as long as great profits can be made in the sale of such drugs, it will be be difficult, if not impossible, to stop both their flow into our nation and the illicit commerce inside the country.

We have a long way to go in winning the war on drugs. Clearly, some of our current problems are the result of a fragmented, undirected policy on the part of the current Administration. Even with a perfect government policy we might not be succeeding in our efforts either to stop the supply of drugs into this country or the demand for them. We must begin to examine some alternative policies.

Therefore, I am pleased the House Select Committee on Narcotics is holding these hearings on legalization. I believe the record developed will greatly contribute to our efforts to solve the crime and drug epidemic now facing us. Again, I commend Chairman Rangel for his efforts and I look forward to reviewing the record you develop.

Drug
Policy
Foundation

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Bernard Simons,
U.K. Counsel and Vice
President
A.C. Martin,
U.K. Program Director

November 7, 1988

The Hon. Charles B. Rangel
Select Committee on Narcotics Abuse and Control
House Office Building Annex 2, Room H2-234
Washington, D.C. 20515-6425

Dear Chairman Rangel:

Thank you for giving me the opportunity to respond to these important questions. Enclosed are my answers to the first and second questions. The third question is answered in the memo I sent you several days ago on the Dutch and British systems. (It is my understanding that the memo, which I sent to your committee staff, will be included in the record.) Enclosed is another copy of that memo plus some additional materials.

I hope these answers I am giving you are helpful in clearing up the misconceptions that have been perpetuated concerning the British and Dutch systems of drug control. If I can be of any help to you in the future on these issues, please call me.

Sincerely yours,

Arnold S. Trebach
President

4801 Massachusetts Ave., NW, Suite 400, Washington, DC 20016
202-895-1634•telecopier, 202-362-7125•telex, 197617 SVEC UT

QUESTIONS FOR ARNOLD TREBACH

1) You made a strong case in your written statement for treating addicts with decency, including at times providing maintenance doses of narcotics through doctors. Is it possible for addicts to live decent lives when the medical system provides them continuing legal supplies of powerful mind-altering drugs?

2) You have taken the position that we should accept the presence of drugs and drug users in our society and that we should change laws and policies based upon that acceptance. Yet, if we accept drugs and change our laws, are we not giving a mixed and dangerous message to our people, especially our youth?

3) At the hearing you stated that the facts about the British and the Dutch systems of drug control were misstated by several witnesses. In your opinion, what are the lessons of the British and Dutch experiences for the United States?

RESPONSES TO SUPPLEMENTAL QUESTIONS SUBMITTED BY THE HOUSE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

By Arnold S. Trebach
The Drug Policy Foundation
and
The American University
Washington, D.C.

October 27, 1988

Q. You made a strong case in your written statement for treating addicts with decency, including at times providing maintenance doses of narcotics through doctors. Is it possible for addicts to live decent lives when the medical system provides them continuing legal supplies of powerful mind-altering drugs?

A. Yes, in some cases. Many addicts fit the stereotype and cannot live with drugs in their lives. Others find it quite possible to function on stable dosages of narcotic drugs. The great difficulty for doctors is to gain the clinical judgment to tell the difference between the good risks and the bad.

British doctors have openly debated maintenance issues for decades. In 1924, their Minister of Health put some of the central questions to a group of leading doctors: "to consider and advise as to the circumstances, if any, in which the supply of morphine and heroin ... to persons suffering from addiction to those drugs may be regarded as medically advisable." In 1926, the Rolleston Committee issued its historic report which described two types of patients for whom long term maintenance on these powerful narcotics was considered proper and helpful. First, "those in whom a complete withdrawal of morphine or heroin produces serious symptoms which cannot be treated satisfactorily under the ordinary conditions of private practice." Second, "those who are capable of leading a fairly normal and useful life so long as they take a certain quantity, usually small, of their drug of addiction, but not otherwise."

I have never heard of a better guide to difficult issues of addict maintenance: you provide drugs to those addicts who can lead decent lives while on them or who have to be hospitalized without them. That should be our guide in this country today.

One of the viewers who contacted me after the hearings knew about the Rolleston Committee report and was outraged that its humane message was not discussed fully before this Congressional committee. He wrote me a letter and urged me to mention it in this statement. This young man had led a horrible, dangerous life as an injecting heroin addict who got his drugs on the street. Methadone maintenance had quite simply saved his life. He wrote me: "I am a 29-year old independent television producer. I received a B.A. in Political Science from a prestigious university and went on to spend five years with a national news organization before starting my own production business. I am happy and proud to be in the so-called American main stream. Unfortunately, according to Rep. Charles Rangel, I do not exist. That is because currently I am a methadone maintenance patient."

The key point for this fine young man was not found in any unique quality of methadone which is a powerful addicting drug. (He might have done well on other narcotics, such as heroin or Dilaudid.) It was rather that he was being treated humanely, was under a doctor's care, his narcotics were legal, and he found he could function on them -- but not without them.

Q: You have taken the position that we should accept the presence of drugs and drug users in our society and that we should change laws and policies based upon that acceptance. Yet, if we accept drugs and change our laws, are we not giving a mixed and dangerous message to our people, especially our youth?

A: No. The only sensible approach for governmental leaders is to explain all of the sometimes conflicting facts and opinions about drugs, their use, and abuse. If government leaders feel uncomfortable talking honestly about drugs -- in the same way as some parents are uncomfortable talking about sex -- then they should encourage the widest possible expression of expert and citizen opinion about the subject. In the end, we must be guided by Jeffersonian democratic principles -- that when ideas are allowed the freedom to be freely expressed in the open market place of ideas, the people in a democracy will more often than not pick the best course of action for themselves and for their society. We accept such glastnost, if you will, about all manner of vital issues, including choosing a president. Yet, our leaders act as if a full and open discussion of alternate drug policies is simply too much for the American people to bear without becoming a nation of junkies.

In my opinion, limited legalization or decriminalization, moderation, and true temperance are the only realistic approaches to dealing with drugs. If we did change some of the drug laws so that some drugs were more readily available, this would cut down on crime and violence and might provide cleaner drugs for those who used. At the same time, we would accompany these legal changes with messages of persuasion and education about the dangers of drugs and the joys of living without them. The message, then, would be clear: legalization or decriminalization do not spell endorsement or encouragement of use.

MEMORANDUM ON THE ENGLISH AND DUTCH DRUG CONTROL SYSTEMS

Arnold S. Trebach
October 27, 1988

Submitted for The Record of the Hearings On
Legalization of Illicit Drugs: Impact and Feasibility

Thursday, September 29, 1988
U.S. House Of Representatives
Select Committee on Narcotics Abuse and Control
Washington, D.C.

During the hearing, I heard distortions about the British and the Dutch systems of drug control stated by many witnesses. Accordingly, I asked the Chair if I could submit a memorandum which would attempt to set the record straight in some essential details. This is that memorandum.

It is important for the American public to be told time and time again that our officials and scholars persistently misrepresent the most basic facts about the operation of the British and Dutch systems. Many scholars have documented those multiple distortions over the years. I have often done so, the last time being in my book, The Great Drug War, in 1987. The following material, especially on Britain, borrows heavily from sections of that book.

Heroin in Britain: The Myths Persist

Heroin in the United Kingdom has always been a subject of great controversy, even in regard to the most fundamental facts. American drug abuse officials over the decades have consistently misstated those basic facts, not only about heroin but about the entire drug situation in England. They have often been aided in their deception by leading electronic and print journalists -- and even worse, by leading scholars -- who seem to take the official distortions at face value. During his 32-year reign as director of the Federal Bureau of Narcotics, Harry Anslinger sometimes had to argue down critics who opposed harsh law enforcement as the dominant American approach to drug issues and who proposed adopting elements of the more gentle British system. Director Anslinger often replied that "the British system is the same as the United States system," and, besides, the so-called British system of decriminalization of drugs has failed. Both statements have always been untrue.

Bureaucratic descendants of Mr. Anslinger have produced progeny of the same doubtful veracity. In November 1984, then-DEA Administrator Francis M. Mullen, Jr. said he opposed the use of marijuana for medical purposes, adding the confusing thought that "decriminalization of drugs has been tried in a number of countries, England being one, and they now are aware that it has not worked." In

November 1985, Mr. Mullen's successor, John Lawn, said in my presence to a seminar of journalists that marijuana, being much worse than alcohol, deserved to be kept illegal -- and then immediately adding the even more confusing thoughts (confusing to me, at least) that (1) "Great Britain tried heroin use for cancer patients and found it to be a failure;" and (2) the recent action of Canada allowing heroin for cancer patients had "the potential for a big problem.... I think its a mistake."

Another major Big Confusion today, which I have heard heard in allegedly factual news stories on major television networks and from scholars, is that the British now have a heroin epidemic which was caused by their curious custom of allowing doctors to give addicts virtually all of the heroin they wanted. The British, the story continues, have come to their senses and have moved almost fully in the American direction of control.

It is difficult to straighten out all of the strands of half-truth and full-lie contained in these various confusing accounts, but here is a summary of the actual situation in that island kingdom. Marijuana barely figures into this discussion of the current British scene because it has been illegal for decades, has been decriminalized in no part of the UK, and is rarely used in medicine. There is little discussion or conflict in that country about the use of marijuana in medicine.

Nor is there any conflict about the use of heroin, or any other powerful narcotic, by doctors in the treatment of the organically ill. It is, accordingly, a simple falsehood for DEA Administrator John Lawn, perhaps the leading drug enforcement officer in the world, to state publicly that the UK has concluded that use of heroin for cancer sufferers has failed or even that any serious questions are being raised about its use for that purpose. The truth is just the opposite.

Approximately 95 percent of all the licit heroin used in the world within recent history has been prescribed by British doctors, primarily for cancer sufferers. Official reports reveal that total annual legal consumption of heroin has been rising consistently in the UK, from 41 kilograms in 1971 (90.2 pounds) to 228 kilograms (501.6 pounds) of the pure drug in 1985.

It is true, however, that many physicians have decided to cut down on the prescription of heroin for the quite legal purpose of the medical maintenance of addicts. In 1969, the first full year in which some new restrictions were in effect on the power of most doctors to prescribe to addicts, 1466 addicts were receiving maintenance doses of narcotics at year's end, of whom 34 percent were prescribed heroin alone or in combination with other drugs. By the end of 1985, only 3.7 percent, 140 addicts out of a total of 7,052 receiving narcotics, were being prescribed heroin. Along with reductions in heroin prescriptions came similar reductions in prescriptions of all injectables for addicts, especially methadone, which most British addicts preferred to receive from their friendly local chemists in ampoules along with clean needles, a shocking and illegal practice in America. Soon British experts began to view that practice in the same light. Oral methadone became the preferred prescription of British drug clinic doctors. Some of the most ignored victims of the American drug war have been British addicts and their families who have been personally affected by the importing of rigid attitudes toward treatment.

It was during this period -- the mid-Seventies to the mid-Eighties -- that there was a rise in crime by addicts and in the black market for drugs, and in concomitant cries by British leaders that the country had to get tougher with these deviants and adopt more American drug war methods. What never seemed to dawn on opinion leaders -- and on physicians and scholars -- in both countries was that *the rise in addict crime and the drug black market took place in the wake of a tougher prescribing policy toward addicts regarding heroin and all narcotics.* I do not mean to say that the tougher policies directly caused the rise in addiction and crime because I have never claimed to understand mass swings in drug use. During this period, I also saw, while on frequent visits to the country, the suffering imposed on the society by economic malaise, massive unemployment, immigration from countries like Iran with a history of high opiate use, and the spillover of supplies from the huge American market. Whatever the causes, it is highly likely that addict crime and black market violence will continue to be incited somewhat by the new British habit of seeking to impose American martial methods on a troubling but still relatively peaceful drug scene.

Even with a modicum of American methods in place, the current English drug system remains a marvel of gentleness as compared to the American and to almost any other on the face of the earth. With all of its current defects, which I have pointed out repeatedly in print and in the electronic media of the UK, it would be marvelous to see it implemented in America. Any doctor in England has the power to decide which drugs patients should receive. If the patient is organically ill, the police tend to keep a decent distance and almost never bother either doctor or patient, no matter what drugs are being prescribed Even if the patient is addicted to one of a wide variety of powerful narcotics, any doctor in England has the power to prescribe the drug of addiction for long-term maintenance so long as the physician keeps accurate records and notifies the Home Office when a new addict is encountered.

However, in regard to three drugs -- heroin, cocaine, and dipipanone, the last a powerful narcotic known as Diconal, suddenly popular with British addicts -- a special license must be obtained from the Home Office by a doctor who wishes to prescribe them to addicts for the purpose of maintenance. Approximately 100 doctors now hold such licenses, most of whom exercise the power only rarely. Yet, any one of those doctors may do so at any time. On the basis of independent clinical judgments, licensed British doctors decided to reduce heroin prescribing to addicts without being required to do so by law, and they may resume without interference by the police.

In short, so long as a British doctor follows relatively non-intrusive regulations, there are no restrictions on the dosage or the form of prescriptions for addicts. For example, any doctor, even one in general practice and without a special license, could prescribe to any addict injectable morphine, methadone, or Darvon, which could land any American doctor in prison, along with the patient. This is not to say there is no risk of prison or professional censure for doctors who deal with addicts. There is, but it is a minimal risk. It rises somewhat in cases where the doctor works outside the National Health Service, is "private," and thus charges fees -- and especially where a patient of such a doctor has been caught selling some of his prescribed drugs. Such events now disturb even the calm British.

The British are also disturbed about many other aspects of the drug scene. As a result, they sometimes declare that they support tough American measures. Yet, underneath it all they remain calm, as they did in the face of imminent invasion in 1940, and true to their most important social values. The Conservative Thatcher Government has recently poured millions of pounds into a series of experiments around the country that are breathtakingly radical, even criminal, by American standards. American officials and scholars, including some who testified at these hearings, seem totally ignorant of these experiments.

Many of the most ambitious experiments have taken place in the Merseyside region located in the Northwest of England. The major city in the area is Liverpool, sometimes referred to as Smack City by the English press. Confronted by increasing crime and drug taking in the early Eighties, the authorities set out to reinvigorate essential elements of the old English system. They set up a wide array of treatment services, all based on the assumption that addicts were sick, decent human beings in need of help. These services included drug-free detoxification facilities, oral and injectable narcotic drugs, including heroin, and a needle exchange program. Their main aim was to get addicts free of drugs, which sometimes was accomplished.

In many cases, however, the treatment experts accepted the reality that many addicts would continue to take drugs. In that case, the sensible English experts decided to see to it that they were healthy using addicts. In some cases, this meant healthy injecting addicts, an obscenity in American eyes.

I have attached two additional documents from English experts which explain the recent Liverpool experience in great detail. These experts demonstrate that those who claim the British system failed are not telling the truth. In Liverpool, crime, AIDS, and drug abuse are being contained. They have not disappeared but they are under control. Addicts are becoming healthier. The police and the treatment professionals are generally united in supporting the system, which emphasizes treating addiction as a health problem -- and plays down the role of the criminal law.

The first document on Liverpool is an excerpt from a report by one of the leading experts in the world on the evaluation of drug treatment and crime control programs, Dr. C.S.J. Fazey of Liverpool. The report is titled The Evaluation of Liverpool Drug Dependency Clinic -- The First Two Years -- 1985 to 1987. The excerpt is Appendix 12 which describes the operational philosophy of the clinic. Please observe the calm language of this statement. It does not say give them heroin and let them overdose if they want; instead, it lays out a whole range of calm options, of which medicinal heroin is only one.

The prescribing policy of the clinic, described on pages 5-7, follows the principles of the Rolleston Committee of 1926: patients receive maintenance prescriptions of powerful narcotic drugs when withdrawal of the drugs produces serious symptoms requiring hospitalization or when the patient can lead a fairly normal life on the drug -- but not without it. These principles are contained in my original written statement. (I was in the process of mentioning them in my oral testimony when I was cut off by the Chair.) Their current use in Liverpool shows that, at least in some parts of the United Kingdom, the old British system lives on and is, by most standards, successful.

Some American officials and treatment experts assume, with Chicken Little, that the sky will fall if such principles are adopted here. The Liverpool experience, as reported by Dr. Fazey, suggests otherwise. For two years under the control of a "consultant" -- chief physician -- who had a liberal attitude toward prescribing injectable drugs, only .4 percent out of the 1019 patients who approached the clinic received prescriptions for injectable heroin. In actual numbers, this was four addicts. Another 5.7 percent received injectable methadone, also illegal in the U.S. The largest single category of first treatment offered, for 58.5 percent of the addicts, was detoxification with the aid of oral methadone. All of these were medical decisions, made in consultation with the patient. The police and the criminal law were not involved.

The most important ingredient was not heroin but the independence of caring medical judgment. During the next two years, doctors might decide that 40 or 400 patients needed injectable heroin. That again would not be a police matter.

The second document is The Mersey Harm-Reduction Model: A Strategy for Dealing With Drug Users, which was just presented at the Drug Policy Foundation's International Conference on Drug Policy Reform. It was written by Russell Newcombe and Allan Parry who are directly involved in providing services to drug abusers in the Merseyside region. They explain how abstinence, the American dream, is possible for some but not all addicts. The overall strategy should be harm-reduction, which accepts the reality of drug use for many addicts and attempts to control its worst features, especially AIDS.

Parry and Newcombe also explain, on page 9, that leading British treatment organizations and the government itself have accepted the lessons of recent experiments, especially those in Liverpool. In a dramatic statement, again ignored by American experts and officials, the cautious Advisory Council on the Misuse of Drugs concluded earlier this year that, "the spread of HIV is a greater danger to individual and public health than drug misuse .... We must therefore be prepared to work with those who continue to misuse drugs to help them reduce the risks involved in doing so."

American translation: put zero tolerance, drug-free America, and abstinence for all addicts on the back burner for a while; lure addicts into treatment with an array of injectable drugs and needle exchange systems; offer them condoms also; teach them how to be healthy, law-abiding stable addicts; in sum, fight AIDS, accept drug use for now. Once lured into the doors of the clinic, moreover, there is a better chance of offering using addicts detoxification services. If they are repelled by a harsh treatment regime, as is often the case in America, they haunt the criminal streets where there is little chance of detoxification and abstinence. And as the treatment experts in Liverpool say, it is extremely difficult to detoxify a dead addict.

Drugs In Holland

To set straight the myths uttered about The Netherlands, I will rely primarily on another two papers from local experts. The first is by Professor Dr. Frits Ruter, which he delivered at a Drug Policy Forum sponsored by the Drug Policy Foundation on Capitol Hill, May 15, 1988. I would emphasize only a few items from the paper of the Amsterdam University professor, who expresses the views of an independent citizen and not the Dutch government.

Like most Dutch experts, he is astonished at the American war on drugs; it gives him the impression of "a fatal marriage between Iranian fundamentalism and Communist economics." At the same time, he sees the Dutch approach as a compromise, as a pragmatic experiment to deal cautiously and perhaps temporarily with an insoluble problem. Yet, unlike the American approach, the Dutch compromise works. "Or, to put it more modestly: it is less unsuccessful than the drug policies of at least some other modern Western societies, including, perhaps, the U.S." Drug abuse, like sexual deviance, is open to the public eye but the number of addicts is relatively stable. So is crime. Youth in the country seem positively bored with marijuana. Unlike in America, with its fierce assault on drugs, cocaine has not stepped in to fill the void left by marijuana. Dutch youth can get all the marijuana they want and they do not want it. Cocaine use is at low levels -- and crack has not even been seen in the country.

Yet, every drug illegal in America is illegal in Holland. The difference is in the spirit of enforcement and a desire to take a calm, peaceful approach to the problem. Possession and small sales of drugs are systematically ignored by the police. Addicts are treated with kindness as members of the Dutch family. Some receive prescription drugs and clean needles. AIDS affects only a tiny percentage of injecting drug addicts.

On Capitol Hill last May, Dr. Ruter said in effect: don't legalize; do what we did; pull the criminal law back into the corner; if that works, then you can go for full legalization of some drugs; if not, move the criminal law back in.

That kind of cautious compromise makes good sense to me.

So also do the sensible ideas expressed in the second Dutch paper enclosed -- Responding to Drug Problems: Dutch Policy and Practice by Drs. E.L. Engelsman, Head, Alcohol, Drugs and Tobacco Branch, Ministry of Welfare, Health and Cultural Affairs. The paper was just delivered at the Drug Policy Foundation's International Conference on Drug Policy Reform. It represents the latest official statement of policy by the Dutch government on the matter. I am inspired much by the pragmatic Dutch and wish to point out that Mr. Engelsman describes their policy as being in the middle ground between legalization and the war on drugs.

How much I wish that my country's leading officials on drug policy took that position.

That is the position I recommended in my original testimony. That is where the major focus of our efforts should be.

Not on fighting over ideological extremes, but rather on negotiating compromises in the middle ground between legalization and the war on drugs.

EXCERPTED
FROM

THE EVALUATION OF LIVERPOOL DRUG DEPENDENCY CLINIC

THE FIRST TWO YEARS

1985 to 1987

A Report to
Mersey Regional Health Authority
by

Dr. C.S.J.Fazey

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APPENDIX 12

THE PHILOSOPHY AND OPERATIONAL POLICY
OF THE
LIVERPOOL DRUG DEPENDENCY CLINIC

Philosophy

Drug addiction is unfortunately a chronic relapsing condition. However it need not be a life threatening condition, nor, if properly managed, need it affect the general health and functioning of the patient. The main aim of the clinic is to reduce, ideally to eradicate, illicit drug use in the catchment area.

The goal of treatment is to return the patient to a drug free lifestyle. However, it is recognised that for some patients this will be a very longterm goal, whereas for others it will be a practical option. Therefore other short and medium term goals must be established as measures of the success of treatment policies and the achievement of the clinic staff.

Having assessed that a patient is opiate drug dependent, the final goal is for that patient to become drug free. This may be done via a methadone gradual reduction programme. If the extent and/or length of dependency and attitude of the patient does not indicate this course of treatment, then stability of the patient's drug taking must be an initial goal. Illegal drug use often leads to wide fluctuations in the amount consumed, and so the maintenance programme should reflect this. Prescribed drugs should be the least amount possible which will prevent discomfort and the onset of the withdrawal syndrome. Other indications of success will include improved physical health, keeping someone from a criminal lifestyle, (as measured by fewer criminal convictions), a reduction in the amount of drug being prescribed, a change in the means of administration of the drug, from intravenous use to oral use or smoking, and greater stability of social circumstances. (As measured by assessments at home visits, or children being returned from care etc.)

There is no known single treatment modality which has proved successful for all patients. After years upon years of research and experimentations with various treatments, it has been found that a variety of treatments need to be offered, and that different patients respond to different approaches, and even the same patient may respond to different approaches at different stages in their addiction.

A drug dependency clinic is just one part of a range of approaches which may successfully be used to offer help to the drug dependent.

All the years of evidence suggests that when someone is addicted, particularly to the opiates, they cannot be treated by being forced off their drug of addiction. To do so leads to a relapse rate in excess of 90 per cent. People will not be forced off the drug, they must be persuaded to stop using, over a long period of time if need be.

When people are forcibly withdrawn from an addictive drug the overwhelming response is to go back to the black market for a supply. The patient therefore ceases to be a patient but does not cease to have a problem, not only now for themselves, but for the rest of society if they resort to crime in order to support their habit, or peddling to finance it.

To reduce the number of people attending the clinic by forcing them off drugs is not considered an appropriate response because the problem of addiction becomes hidden, it is not solved and nor is the patient returned to a healthy drug free life. In fact he/she will almost certainly be pushed into a more unhealthy lifestyle~~,~~ and more people put at risk.

Many people who are drug dependent are unable to contemplate, in the short term, being drug free. This is not seen as a reason for turning people away from treatment. Part of the task of dealing with those who are drug dependent is to bring them to a point when they are willing to consider a drug free life style and will cooperate with measures to achieve this end.

Therefore for some patients, the initial appropriate method of treatment would be to give them a maintenance supply of the drug which they are using or a pharmacological substitute for it.

There are also people who seek treatment and help for their drug problems who have not been addicted for any length of time, and/or are taking the drugs in comparatively small quantities. Maintenance would not necessarily be the most appropriate initial response here; either no medication or a gradual reduction course of oral methadone may be preferable.

Those patients who are neither committed to the lifestyle often associated with addiction, nor the self-image of an addict should be discouraged from so being. To this end great care must be taken when dealing with young people so as not to confirm them in their addiction. Nevertheless it is recognised that those who smoke heroin can become dependent on the drug, and must be treated with the same concern as those who use a different means of administration. Heroin smokers, and even those using heroin intravenously, range from those who use the drug recreationally and do not think that they have, or are likely to have a problem, to those who are heavily dependent on the drugs. In between may be the user who believes that he/she has a problem although they are not physically addicted, to those who are physically addicted but have convinced themselves that they have no problem.

The patients likely to come forward for help are those who believe that they have a problem, whether they are physically addicted or not. It is the role of clinic staff to carefully assess the situation and to judge the extent of the addiction, and the capacity and willingness of the patient to refrain from drug use. It is recognised that there are always people who obtain services and treatment which are inappropriate. Through mimicking symptoms there are patients who abuse the Health Service and have operations, sometimes major ones, when there is nothing wrong with them. Similarly, there will be patients who come forward for treatment, and manage to lie sufficiently well to deceive their own G.P., as well at least two clinic staff even after undergoing an in-depth extensive interview. Such people might receive a prescription when they should not. However it is a recognised phenomenon throughout the world that wherever there are drug clinics some people will try to get drugs that they do not need, and that a few of these will escape the screening procedures. Estimates in other countries suggest that there will be about 4 to 5 percent of such patients. While this is unfortunate and everything needs to be done to minimise the number of these pseudo-patients there is no way in which they can be eliminated altogether other than by a policy of no prescribing to the needy and charlatans alike. To penalise 96 people for the sins of 4 does not seem to be a responsible way to deal with patients. Those patients who lie and cheat to get prescriptions may harm themselves, but the vast majority who need help cannot be sacrificed for the mendacity of a few.

Prescriptions are given on the basis of clinical judgment, whose foundation is that the patient is drug dependent. As already stated this dependence can occur whatever the route of administration, whether it be by intravenous injection or smoking or swallowing the drug. To give supportive medical help to one group and to deny it to another solely on the basis of the means of administration of the drug (such as intravenous use versus smoking) is neither equitable nor in the best interests of the patient, for it does not serve the purpose of harm reduction.

Further, such distinctions may actually encourage both an escalation of the seriousness of the addiction and prove a powerful encouragement to adopt a more dangerous means of administration. To provide maintenance prescriptions only to those who use the drug intravenously would be to encourage those who have become dependent through smoking heroin to take the drug intravenously in order to get help for a problem which they cannot envisage being solved.

In view of the dangers of Hepatitis B and AIDS, not to mention the other adverse health consequences of illegal intravenous use, all efforts must be made to keep drug dependent people, particularly young people, away from this more harmful means of drug use.

Efforts must also be made to persuade patients to change from intravenous to oral drug use. This persuasion may at times be in strong terms, but coercion is not a treatment option. No patient must be forced into a course of action or presented with alternatives which in fact are not real options. (Such as in-patient treatment versus no treatment). Relapse to illicit use is the almost inevitable consequence.

For those on a maintenance programme, the priority is to establish the correct amount of the drug needed and to stabilise the patient's life. Efforts should also be made to reduce the amount of drug being prescribed, as part of an agreement or contract with the patient. It is recognised that patients may come down to a new level and stay at that plateau for some time, before another reduction can take place. Equally, occasions may warrant an increase in the prescribed dose.

Operational Policy

Nature of Client Problems
The clinic is established to deal with people who have opioid dependency

problems. Patients with other substance abuse problems may be seen by special arrangement with the Medical Director of the clinic.

Catchment Area

The catchment area for the clinic is comprised of the Health Districts of Liverpool and South Sefton. Patients are also taken from some parts of Kirby in Knowsley (excepting Maghill and Lydiate, which are currently served by ormskirk). Patients ouside this area cannot be seen by the medical staff. Patients from any other districts of the region may be seen by the Director of the clinic if requested to do so by the consultant psychiatrist dealing with drug addiction in the referring district.

Referrals - Who Can Refer?

In order to receive medical treatment a patient must first be referred by his/her own G.P.

However, anyone, whether drug user or parent of one, or other relative may discuss problems with the nursing or social work staff. A nurse or social worker will be available 9am to 5pm weekdays to provide advice.

If subsequently the person needs to see a doctor, they will still have to go back to their own G.P. for a referral note.

Referrals to see medical staff cannot be taken from any other agencies. Other agencies, however, might seek advice from colleagues in the management of drug dependent clients, and this is to be encouraged.

Inappropriate Referrals

Some patients are referred to the clinic, who, in the opinion of the staff do not have a serious drug problem, or who are not addicted, or have drug problems with which the clinic does not deal (such as alcoholism). In line with the policy of not drawing people, particularly young people, into the clinic to mix with patients who are drug dependent, the patient will be counselled, perhaps visited at home, and/or referred to another agency if it is felt to be more appropriate.

Where staff time is available young referrals should be seen by the social worker or a community psychiatric nurse at home.

If a home visit is attempted and there is no reply, or the address given is false, then the appointment given will not be cancelled but an explanation asked of the patient when they come to the clinic. There may have been a credible reason for not being at home for the visit, or for giving a false address if the patient wished to keep the fact of their addiction away from parents. In the latter case the correct address must be given and appear on the case notes.

Age of Referrals

No referral under the age of 16 will be accepted without the presence in the clinic of at least one parent or legal guardian. All such patients will be seen only by the Consultant. Special arrangements will be made to see such patients outside normal clinic times, so that the patient does not mix with older patients.

Referrals with Special Problems
All patients with severe psychiatric problems, those with additional illnesses to their addiction, and pregnant patients will be seen by the Consultant.

Should a patient being seen by a G.P. become pregnant, then the management of this patient must be discussed with the Consultant, who may, if he thinks it necessary, take over the care of the patient.

Waiting List
It shall be the policy of the clinic that new patients will be seen within a fortnight of receipt of their referral letter.

Initial Assessment
The initial assessment of the needs of the patient, together with details of their medical, psychiatric and social background, will be taken using the client record sheet.

A urine sample will also be taken and analysed. If the staff are not satisfied that the sample is the patient's own, or that the patient is not as dependent as he/she is claiming, then another sample may be asked for.

At this assessment a treatment plan will be drawn up and the programme explained to the patients.

Prescribing Policy
No patient will be given a prescription for any form of opiate drug unless the patient provides a positive urine sample. (That is, a sample of urine in which the presence of opiate drugs is detected.)

Patients shall, in general, receive prescriptions for opium analogues in accord with the policy laid down by Rolleston (1926), viz.;

The "circumstances in which morphine or heroin may be legitimately administered to addicts" included the administration of drugs to addicts undergoing treatment by the "gradual reduction method" as well as for "persons for whom, after every effort has been made for the cure of addiction, the drug cannot be completely withdrawn, either because:

(i) Complete withdrawal produces serious symptoms which cannot be satisfactorily treated under the ordinary conditions of private (that is general) practice; or

(ii) The patient, while capable of leading a useful and fairly normal life so long as he takes a certain non-progressive quantity, usually small, of the drug of addiction, ceases to be able to do so when the regular allowance is withdrawn."

For most patients, particularly young patients, the initial treatment option is likely to be a reduction course of oral drug. The period of withdrawal of the drug will vary with the clinical circumstances of each patient.

If a patient convinces the staff that he/she cannot cope with the withdrawal course, or has tried such a course and could not manage the reduction, then the patient may be prescribed for on a regular basis. The object here would be to stabilise the patient's drug consumption with a view to persuading them through counselling to begin a slow reduction programme. This reduction programmme may take place over a very long period of time - months if not a year or more. However, as long as the dosage is slowly decreasing then the plateaux inbetween the reductions are acceptable. Nevertheless, it must be understood that the lives of drug dependent patients are not altogether stable and crises might occur for which a temporary increase in medication is called for.

Normally the initial prescription is about 50mls heroin equivalent daily, but for severely dependent patients this might have to be revised upward. Initially, significant changes in the drug dose should be discussed with the consultant

There are also a few patients who have a considerable history of drug misuse and dependence, for whom a reduction regime would be inappropriate unless they had sought help for becoming drug free. With these patients, who may have been drug dependent for over ten years, then the treatment plan will be proportionally over a longer period of time, and the health and stability of the patient become the immediate and mid-term goals.

No new patients shall be given a pescription for intravenously administered drugs without first discussing the case with the consultant.

Efforts shall be made to persuade those patients taking their drugs intravenously to change to oral use. Such a change may often take place over a very long time, and may involve a slight increase in the total amount of drugs supplied but a reduction in the amount prescribed for intravenous use.

No patient should be forced to change either the means of administration or the amount received, because this would encourage a return to the black market and chaotic use, and undo all the work previously put in by the clinic staff. By the same token the patient may not demand an increase in the amount of drug received, nor a change to a more harmful means of administration. If, in the opinion of the clinic staff, such changes are required then the case should be discussed with the consultant.

In the opinion of the consultant it is good clinical practice to stop prescriptions after transgression of the rules. The reasons for stopping prescriptions have been failure to attend for an appointment, producing a substitute urine specimen and producing a urine specimen which proved negative for the drug prescribed by the clinic.

The patient may, in fact, have a reasonable explanation for not being able to attend the clinic. It is also strongly recommended that if a prescription is to be stopped on the basis of a negative urine test, then the test be re-done, preferably where possible by another operator. There has been some concern that operator errors have crept in, and false readings produced. Those concerned with the operation of the Emit testing machine will receive regular retraining sessions. It may ease the situation when a prescription is finally stoppped for the patient to sign in his/her notes acknowledging the first warning.

Any problems consequent upon the stopping of the prescriptions must be dealt with by those who took or were a party to that decision. Phone calls and visits to the clinic by irate patients must be dealt with, and if the people are not available at that time, then an appointment within a reasonable time must be made to explain the decision and what is expected of the patient in order to get the prescription restored.

Lost Prescriptions

If a patient loses a prescription or medication for whatever reason, it is clinic policy not to replace it.

The only exceptions are where a patient drops their medication on the floor of the chemist's shop in the presence of the pharmacist, and the bottle breaks, or on the floor of a police station and is so confirmed by the police.

If a patient claims that another has picked up their prescription then a replacement might be given if the patient makes a formal complaint to the police, and the pharmacist confirms that the prescription has been dispensed, and that it was not dispensed to the patient, or that he/she is not sure to whom it was dispensed.

In-Patient Treatment

In-patient facilities are available at the regional facility, The Thomas Percival Clinic at Winwick Hospital. Patients may be referred there by the consultant only. Any staff who believe that a patient is ready to detoxify and undergo a period of psychotherapy at the in-patient facility must discuss the case with the consultant.

Patients Who Cease to Attend the Clinic

Many patients drop out of treatment and then re-present themselves for treatment. If a patient has been absent from the clinic for more than six months, then they must get re-referred by their G.P.

If, however, a patient has been absent following an apparently successful reduction course, then they should be given an appointment as soon as possible. The reason being that the clinic should not discourage people from undergoing reduction courses. Many patients are frightened to try a life without drugs in case they relapse and cannot manage. To be re-assured that, should they fail, they will still be taken back, may lead to more patients willing to try. Although there is a school of thought which suggests that if the patient knows that they can come back to the clinic should they relapse and be seen at fairly short notice undermines the motivation to stay drug free. There is no absolutely right answer, the choice is an invidious one. On balance the encouragement to try to be drug free is felt to be more important than the encouragement to stay drug free, because the latter can only come about as a result of the former. Indeed other agencies should be involved in the effort to keep drug free patients in that state.

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Responding to drug problems: Dutch policy and practise

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Introduction

The aim of this paper is to elaborate on the principles of drug policy in the Netherlands. To many people this policy may seem radical or at least controversial. The aim is to shed some light on the objectives and practical experiences acquired in this country.

The Netherlands drug policy is in essence not different from drug policies of most other countries. The Single Convention on Narcotic Drugs has been ratified and the Dutch adopted drug legislation which penalizes the possession of drugs, including hashish and marijuana. However, the Netherlands is reputed for the individual character of its drug policy. Unfortunately, this reputation is sometimes based on misconceptions of Dutch legislation and legal practice, if not of Dutch culture as a whole.

Dutch measures for controlling drug problems can only be understood in the context of history and culture combined with the policy of social security based on solidarity.

Let me therefore clarify some backgrounds.

The Netherlands is a small country. Bounded by the North Sea on the West and North, by Germany on the East, and by Belgium on the South, it covers a land area of almost 13,000 square miles - about one fourth of the size of New York State. Within this territory live more than 14.5 million people, including some 600,000 foreigners, making the Netherlands one of the most densely populated countries of the world. In the past hundred years the country has developed into a modern industrial society.

The city of Rotterdam (the second city of the Netherlands) exemplifies the importance of foreign trade. Thanks to its huge transit traffic, it is the largest port in the world.

Even such a seemingly unhistoric factor as geography should be interpreted in the light of history and culture. In the case of the Netherlands, this is particularly obvious, as borne out by the proverbial statement that 'God made the world, but the Dutch made Holland'. Indeed, a great deal of the physical landscape is literally man-made, about a third of the country, consisting of former swamps, lakes or even patches of sea drained one by one and turned into valuable polder land. To foreign observers the most striking feature of the Netherlands has always been the abundance of water: water constituting both a threat and a means of livelihood, necessitating the building of dams and dikes, and drawing the people toward seafaring and trade. The Dutch have never conquered the sea but succeeded in controlling this enemy. Surely this factor of natural environment has provided an important stimulus to a realistic and pragmatic attitude to life in general.

Social security system

More than three and a half centuries of national existence have made the Dutch society a close-knit, distinctive whole. There are also many differences, both geographical and culturally: Amsterdam is not equal to the country as a whole. The differences have been jointly incorporated in the institutional pattern of Dutch society, safeguarding unity as well as diversity. Indeed, the conscious commitment to the values of both unity and diversity seems to be one of the key aspects of Dutch society. Expressed in the idea of tolerance, this twofold commitment has always been a prominent tenet in the national ideology.

The idea of tolerance is matched by the idea of orderliness. Nonconformity in thought and behaviour, such as prostitution and homosexuality, is tolerated as long as it does not harm other citizens, with a relative absence of penal law. The concept of unity is also expressed in the system of social security. The State has been charged with the social rights. Today it guarantees a minimum income to every citizen on the basis of the National Assistance Act and on the basis of several other Acts by supplying old age pensions, widow's and orphan's pensions, family allowances, and insurance benefits in case of sickness, disability, or unemployment. It sets minimum standards of housing and food and sees to it that these standards are met.

It sponsors a system of medical care covering health insurance for all wage earners below a certain income level. The state further provides school education at mimimum costs, and it grants scholarships if necessary.

All these arrangements are not regarded as acts of charity that might be revoked at will, but as inalienable attributes of social justice. The more a society succeeds in protecting its members from poverty and hopelessness, being a breeding ground for drug use, the more it will succeed in reducing the demand for drugs.

General principles of Dutch drug policy

Dutch drug policy is often considered as an 'experiment' by foreign people. Although Dutch drug policy is deliberately designed, it should not be seen as a specific policy that is totally different from policies on other areas in society. It is just an example of the way in which the Dutch try to control or to solve their (social and medical) problems. This approach fits into Dutch culture and society and that is why it works in the Netherlands. If the Dutch would give up their drug policy, they would give up their historical and cultural identity. The Dutch being sober and pragmatic people, they opt rather for a realistic and practical approach to the drug problem than for a moralistic or overdramatized one. The drug abuse problem should not be primarily seen as a problem of police and justice. It is essentially a matter of health and social well-being[1]. That is why reponsibility for coordinating drug policy in the Netherlands lies with the Minister for Welfare and Public Health.

It should be emphasized that the role of the penal system and law enforcement in the Netherlands is not as prominent as in many other countries. Dutch people favour a policy of encirclement, adaptation and integration. Although Dutch drug legislation is still a part of criminal law, it is generally considered as an instrument of social control, the results of which should be assessed with each case, and it should not be considered as a mouthpiece for passing moral judgement. Drug legislation remains supplementary to the (informal) social control, which has for centuries been established on traditionally tight family structures conforming with a Calvinistic life-style.

Although this paper is written by a health official, it will devote some space to aspects of the reduction of drugs supply. It is a well-known fact that demand and supply reduction are not two separate worlds, but are closely related. The effects of repressive law enforcement towards drug users and illicit traffickers influence the nature and the magnitude of the health and social problems of drug addicts to a large extent. It is very often forgotten that drug dependence syndroms as they appear to treatment and counselling staff are partly the product of the repressive control-of-supply policy. Moreover the nature and the extent of the harmfulness of drugs are often misinterpreted as they are based on these clinically described dependence problems and not on drug use experiences outside the treatment system.

Present-day drug policy in the Netherlands has largely been determined by the 1972 publication of the recommendations of the Narcotics Working Party,entitled: Backgrounds and Risks of Drug Use,[2]. The Working Party concluded that the basic premises of drug policy should be congruent with the extent of the risks involved in drug use. These risks, or the likelihood of harmful effects, are categorized according to the properties of the substances taken. However the -social-background of the users, the circumstances in which the drugs are taken, the subjective expectancies and the reasons why people use drugs are at least as important as the pharmacological properties. Especially the reasons of use are of decisive importance as it makes a big difference whether one takes a drug for relaxation and recreation (think of alcohol and marijuana) or with the aim to overcome problems or to cope with a hard life, as a form of self-medication. The effects are also different.
The penal approach should be left aside as much as possible and ought to be substituted by other methods of prevention, such as health education.

The 1976 Opium Act and the prosecution policy

The differentiation in risks is reflected in the amended 1919 Opium Act, which came into force in 1976. Thus the Amended Opium Act draws a distinction between "drugs presenting unacceptable risks" such as opiates, cocaine, LSD, amphetamines on the one hand, and "hemp products", such as hashish and marijuana on the other hand. The maximum penalties for illicit trafficking in drugs with an unacceptable risk were considerably increased to a maximum of 12 years imprisonment and/or Dfl. 1 million fine; (under certain conditions, e.g. when a crime was committed more than once, this maximum may go up to 16 years or higher). Maximum penalties for possession of small quantities (up to 30 grams) of cannabis preparations for personal use were reduced from an offence to a misdemeanour, that is one month detention or Dfl. 5,000 fine.
The Dutch do care about the related health hazards and therefore try to address the next obvious question: what policy could lead to the lowering of drug consumption? In this regard the Dutch prove very pragmatic and try to avoid a situation in which consumers of cannabis suffer more damage from the criminal proceedings than from the use of the drug itself.
This requires a restrained attitude on the part of the state and the pragmatic intentions enable such attitudes to events in practice. Prosecutors are empowered to refrain from instituting criminal proceedings if there are weighty public interests to be considered. New guidelines with priorities have therefore been established for investigating and prosecuting offences under the Opium Act. Investigation of the import and export of "drugs presenting

unacceptable risks" takes priority above investigation of the possession of "hemp products" for personal use.
In a nutshell, the application of the expediency principle implies a pragmatic prosecution policy. If criminal proceedings against cannabis users do not eliminate the drug problem but aggravate it, the law steps aside. The same principle accounts for the sale of limited quantities of hashish in youth centres and coffee shops. This aims at a separation of the markets in which hard drugs and soft drugs circulate. According to the Minister of Justice this restraint policy succeeds in keeping the sale of hashish out of the ambit of "hard" crime as much as possible.[3]
This practice also prevents young people from going underground. If that were the case, the social surroundings in which hashish circulates and those in which heroin and cocaine appear, would mix up. This somewhat controversial Dutch practice should not be misinterpretated as a tolerant or lenient policy. It is, on the contrary, a well-considered and a very practical policy. The Dutch do not want to hide the problems of their society as they do not want them to get out of control.

Results of cannabis policy

The policy of de-facto decriminalization of cannabis does not produce more drug use and has proven to be very succesful. The prevalence of cannabis use in the Netherlands is low. In the age bracket between 10 and 18 years, 4.2 per cent have ever used cannabis (life time prevalence). Among them 1.9 per cent are still using occasionally. The number of daily cannabis users appeared to be one in a thousand (nationwide school survey; N = 25,000 ; 1984)[4].
As is well-known the prevalence of drug use is always highest in metropolitan areas. Therefore the Dutch carried out a household survey in Amsterdam, in December 1987 (N = 4370) among respondents of 12 years and older[5]. The average life time prevalence of cannabis use was 22.8 per cent. The so-called last month-prevalence of cannabis use appeared to be 5.5 per cent. The highest last-month-prevalence was found in the age bracket of 23 and 24 years: 14.5 per cent. These percentages include even people who have used cannabis only once in the previous month.

THE DUTCH ALTERNATIVE: NORMALIZATION

On the international level most states have always pretended to have high moral and ethical standards and have aimed at a total banishment of all drugs. Last year during the UN Conference on drugs most countries were prepared to take far-reaching law enforcement measures and this escalation has been going on for years[6]. In reality, whatever governments may wish or do, very far from all young people are deterred by the threat of punishment, or indeed by the health hazards. Neither can present drug education efforts keep thousands of young people from using these substances. The question is how to deal with these facts and which policy could lead to the optimal results. In answering this question one should take into account the national socio-cultural circumstances and the cost-effectiveness of any proposed solutions. The present attempts in the UN to merge national drug policies into a single global approach are bound to prove counterproductive for many countries.

Such a universal approach neglects cultural, economic and legal differences among all member countries: the drug problem in individual countries would only be superficially dealt with.

Intentional and unintentional effects of drug policy

In drug policy the objectives are sometimes conflicting.
Due to the direct (psychotropic) effects, governments try to discourage use through the penal system and health education. The direct effects form the primary problems, and are seen as the initial reason for passing international conventions. Nowadays we see addicts affected by additional medical and social problems. Medical problems are increased by risks of infectious diseases, prostitution and social ostracism and these complications are caused by pushing drugs into the illegal sphere. On the social level, additional problems have arisen from the intensified approaches toward drug trafficking, and the adoption of new far-reaching legal measures, which have led to increasing corruption of the police, the judiciary and government authorities in some cities and states. All this leads to a "war on drugs" that enhances the escalation of criminal activities. These additional problems - both medical and social- form the secondary problems, the unintended side-effects of our drug policy.
It would be a mistake to confuse the primary and secondary effects of drug abuse. It is not always easy to differentiate between these effects because the appearance of the secondary problems, e.g. criminality and certain health problems, has overshadowed the "original" health problems. The primary effects, however, must remain the basis for drug policy including the legal measures. This pragmatic approach implies a strict distinction between enforcement policies applied respectively to drug takers and drug traffickers.
The possibility of conflicting consequences stemming from drug policies imply a social dilemma that needs discussion and which cannot be ignored on the international level. In any case more and more people get involved in such a debate in the Netherlands.
Is there any room for adjustments?

Legalization?

An intensified war on illicit drugs is one extreme option. At the other extreme there is legalization of the availability of drugs. It is clear that one may advocate legalization without having any compassion for drug addicts or without taking into account the addict's interests. The mere apprehension of the threat to the civilized legal system or the fear of an escalating arms-race between police and traffickers, may provide arguments that sound realistic. A plea for legalization does not mean that the harmful physical effects of drug use are denied or ignored. In fact, the health issues are of primary concern. The problem is indeed severe, but the cure (that is, the current drug policy) could be worse than the disease[7].
It is unrealistic to assume that with legalization international criminal organizations would terminate their illegal practices, at least in the short term. Alcohol prohibition in the USA nourished such mafia-type-organizations. Opportunity made the thief. Other illegal criminal activities started after the abolition of the prohibition. However, thinking the unthinkable, it is possible that in the long term legalization of drugs could lead to a lower crime rate.

Furthermore it is unknown to what extent drug use will increase or decrease in such circumstances. However, the nature of the addiction problem could in a decriminalized or depenalized situation, which is totally different from a "free" situation, take on a less malign character. I will come back to that. At this moment there is no major political support for the legalization of drugs in the Netherlands. The Netherlands government does not find itself on an island and wants to fulfil its obligations stemming from the international drug conventions.

Compromise between a "war on drugs" and legalization

Nevertheless, the Dutch have adopted their own, alternative way within the boundaries of the internationally prohibitive approach. It is a compromise between legalization and the war on drugs. It should be stressed that this orientation is a desirable approach in the cultural circumstances of the Netherlands.

The Dutch Government feels the need to contain the additional (secondary) problems as much as possible. A gradual process of controlled integration of the drug phenomenon in society may teach its members to cope better with this happening. The addiction problem will continue to exist but it could be reduced from one on a collective, social level to one on the individual level. It is another way of looking at things, not by denying that drug addiction may cause severe individual and family problems, but by demistifying the popular views on drug use. Integration does not mean acceptance, but discouragement of use is not identical with criminalizing the consumer. This approach could be compared to the alcohol- and tobacco-control policies and particularly to Dutch policy on cannabis. Out of 14.5 million inhabitants in the Netherlands in 1986 about 18,000 people died from smoking, about 2,000 deaths were directly related to alcohol abuse, and only 64 Dutch citizens died from drug use. The reaction of society to these figures is rather surprising. It is able to cope with alcohol and smoking problems without emotional overtones and fear that the survival of our western civilization and society are at stake, but it is not prepared to accept drugs as the cause of an even insignificant number of deaths. The Dutch Government wants to remain credible and does not want to encourage messages to youngsters such as "your drugs are killers, but ours are pleasures". Young people are very sensitive to such moral double standards.

The above mentioned line of thought was worked out in the memorandum of the Interministerial Steering Group on Alcohol and Drug Policy, entitled: Drug Policy in Motion: Towards a Normalization of the Drug Problem (1985)[8]. This policy has been adopted by the Government. A process of normalization of the drug phenomenon was advocated, which could possibly lead to a de-stigmatization of drug users. This does not mean that this phenomenon has been spirited away, but it has been put in another perspective in order to enable society to face the problems from a realistic point of view, unobscured by moralistic colouring. The process of normalization implies a change of climate. The pragmatic aspects of drug policy must be emphasized: that is a more factual and realistic approach instead of an over-dramatized one. A sound approach also means that the drug problem should not be considered as a specific social issue.

Normalization and prevention

In drug policy we encounter an often underestimated process. Part of the process of criminalization is the labelling and stigmatization of drug abusers. Paradoxically some young people are attracted by the exciting and glamorous life-style of being a deviant person. It is difficult to find a social position to which society would pay so much attention as to that of a drug consumer. The police hunt them, treatment personnel quarrel about the most appropriate approach, educators try to warn or deter them, some politicians consider drug addicts as the plague of the twentieth century and the population is scared. Could they themselves ever wish for more attention? And attention is what many drug consumers need and want. The rejection of addicts by society may encourage or reinforce such life-styles. Repression towards experimenters might have the same effect.
Prevention should therefore eliminate the fascination with and misplaced idealization of a user. The phenomenon of drug use should be shorn of its sensational and emotional overtones and be made more amenable to an open discussion. Being a "junkie" should be de-mythologized and de-glamourized. By pursuing drug policy in the way at present favoured by most countries, a specific "meaning" is attached to drug use. The less "meaning" authorities attach to the drug phenomenon, the less "meaning" it generates for addicts.
This indicates that drug takers or even addicts should neither be seen as criminals, nor as dependent patients, but as "normal" citizens of whom we make "normal" demands and to whom we offer "normal" opportunities. Addicts should not be treated as a special category. The policy of normalization is based on well-considered strategic planning and does not favour a laissez-faire approach.
Concern must not accompanied by exaggerated attention.
The health risks have neither been ignored nor minimized. The mere thought that cannabis is smoked with tobacco provides a reason for concern. Much attention to cannabis is paid in education programmes, albeit as a part of an integrated approach aimed at a healthy life-style. Learning how to cope with risk involving behaviour (including alcohol and tobacco use) and how to be responsible for one's behaviour and choices, is better than simply deterring and warning people. Most mass media campaigns miss direction and are for that reason not considered effective. Publicity sensationalizes the dangers of drugs and may even create curiosity and encourage experimention with drugs.

A "normalized" treatment policy

What are the implications of normalization for the treatment of addicts? Present treatment policy is a mixture of traditional medical practise and a recognition of the importance of social background. Furthermore treatment policy fits into the more general principles of the social and health care. It also acknowledges the fact that our drug policy unintentionally produces additional health and social problems.
In the seventies treatment concentrated too much on ending addiction without necessarily meeting the needs of the heroin addicts or helping them to function within society.
Treatment was carried out in outpatient facilities and addiction clinics, the latter being mainly drug free therapeutic communities. These facilities required the patient's willingness to become abstinent.

Consequently, addicts who did not feel the need to "kick the habit" or were not capable of doing so, remained beyond the reach of the health care system. This led to further social isolation and degradation.

The philosophy of abstinence was heavily criticized by the larger municipalities, as they were confronted with addicts who were not accepted by the community and who caused annoyance in some neighbourhoods, ranging from streets crowded with prostitutes and their customers to areas frequented by drugs dealers.

In the eighties a new treatment philosophy emerged which stressed the socially backward position of most drug addicts. Increasing encouragement by the Government has been given to forms of aid which are not primarily intended to end addiction as such, but to improve addicts' physical and social well-being and to help them to function in society. At this stage the addicts' (temporal) inability to give up drug use was being accepted as a fact[9]. This kind of assistance may be defined as harm reduction or more traditionally: secondary and tertiary prevention. Its effectiveness can only be ensured by low treshold-facilities and accessible help, which are the key concepts in Dutch drug policy. This takes the form of: field work on the street, in hospitals and in jails, open-door-centres for prostitutes; the supply of the medically prescribed substitute drug methadone; material support; and social rehabilitation opportunities.

The supply of methadone (including in the rebuilt city buses, for instance in Amsterdam) is only possible after having been examined by a doctor and on medical prescription. In Amsterdam the conditions for participation are a regular contact with a medical doctor, the introduction into the central methadone registration and no take home dosages.

The so-called "junkiebonden", a sort of trade-unions of addicts, have been promoting their interests and have been contributing to a serious attitude of local and national authorities towards addicts.

The Junkie Unions are able to reach those addicts who cannot be reached by any "official" aid service. This is also very important in relation to Aids-prevention. They receive a subsidy from the Ministry of Health to dissiminate brochures on "safe sex" and "safe drug use".

The fact that the Government wants to encourage assistance to addicts who are not able or do not - at least for the time being - want to establish a drug free life-style, is indicative of the realistic and pragmatic Dutch approach. It also shows the determination not to leave drug addicts in the lurch. Failure to provide care of this type would simply increase the risk to the individual and society. This type of assistance has neither the intention to coddle people, nor does it legitimate or encourage drug use. Nevertheless, the treatment personnel must always keep asking the question where to set the limits in their approach. The life-style led by an addict must never become his profession. Field studies carried out by Kaplan and De Vries in Rotterdam of low-treshold methadone clients as well as "street addicts" have shown that the "typical" addict is in no way an anti-social monster[10]. The studies have shown that the majority of addicts' time allocation is engaged in social activities, such as self-care and leisure (watching TV, going to disco). Compared to control groups of "normals", they are alone less and spend more time with significant others. They are with other people 70 percent of the time. Their drug activities seem to be functional substitutes for what in a "normal" control group are work and study activities.

Significant others are often dealers and "partners"/peers. The function of junky unions in this behaviour is to insert as a significant other a community member who is representing a positive social activity, i.c. political action and organizational responsibility. "The preliminary results of this research is underlying the importance of protective factors as primary mobilizers of health and harm reduction. The Dutch policy of the normalization seems to have produced a context where the addict seems more to resemble an unemployed Dutch citizen than a monster endangering society. The Rotterdam studies are documenting a large prevalence of "social buffering" in which addicts spend a lot of their time at home in the company of others engaging in non-drug-seeking behaviours. Society seems to be being used as a buffer against their compulsions."

AIDS and treatment policy

The result of the Dutch health policy is that the Dutch aid system (treatment and counselling) obviously is able to reach a major part of the total population of drug addicts. In Amsterdam about 60 to 80 per cent are being reached by any kind of assistance[11]. This percentage is certainly higher in less urbanized regions. This has to be seen as a very positive development, especially since keeping in contact with addicts is a prerequisite for AIDS-prevention. AIDS-prevention aims at changes of life-style. It teaches addicts to 'use safely', that is to say not intravenously, and to have 'safe sex'. Needle-exchange programmes fit into this practical approach as it is an established fact that many drug users are using intravenously and share needles. Only 8 per cent of all 605 Dutch AIDS-patients are drug addicts (October 1, 1988). In Europe this is 23 per cent (June 30, 1988) and in the United States 26 per cent (September 26, 1988). The prevalence of HIV in a non representative sample of high risk intravenous drug users in Amsterdam was approximately 30 per cent (1987). Outside Amsterdam in three smaller cities the infection rate was 3.6 per cent (1986)[13].

Conclusions from the first evaluation of the needle/syringe exchange programme[12] in Amsterdam should be drawn very carefully since the data are based on reports made by addicts. No testing on HIV was done and a follow-up has not yet been carried out.
The present data show that:

- differences were found between 'needle-exchangers' and 'non-exchangers' on a number of characteristics,
- no increase in drug use was reported by the 'needle-exchangers',
- the exchange schemes stimulated a certain group of IV drug users to take drugs in a safer way with regard to HIV infection,
- the exchange schemes contact addicts not visiting regular health care facilities.

No negative side effects, such as an increasing number of IV drug users,an increase in drug use or reduced interest in drug free treatment, were reported in the study in Amsterdam.
On the basis of the Amsterdam experience no definite answer can be given to the question whether needle/syringe exchange schemes are effective tools in the fight against the further spreading of Aids. Although safer drug use has been reported by a large percentage of the IV drug users in Amsterdam, some addicts are still (occasionally) involved in needle sharing.

Other results of drug policy.

Apart from the positive effects of normalization described above, there is also the effect of prohibition, which is still in existence. Some addicts commit crimes, mainly thefts, but addiction is never an excuse for committing a crime.
The policy of normalization did not produce higher crime rates. After an increase, registered crime has been stabilized since 1984. In comparison with many other European countries crime is even lower.

Registered crime per 100,000 inhabitants

Year	Netherlands	England	France	W.Germany	Sweden
1984	6850	7047	6817	6755	10160
1985	6906	7258		6909	
1986	6910	7707		7154	
1987	6998			7269	

Source: Ministry of Justice, Scientific Research and Documentation Centre.

The number of murder and menslaughter cases in the Netherlands is also lower than in some other countries. These cases are mainly not drug related. Last year this figure was 1.11 per 100,000 inhabitants for the whole country, whereas this figure was 8.3 in the United States; England: 1.23 (1986); W. Germany: 1.4 (1987).

In Amsterdam, with 640,000 inhabitants, this murder rate was 5 per 100,000, namely 33 cases. The city of Washington which has a smaller population (622,000) had 225 murder cases. Boston, also with a much smaller population (575,000) than Amsterdam, had 76 cases.

About one third of people who are detained are drug addicts. In the western part of the country this figure goes up to 50 per cent. These people are incarcerated for drug related crimes and not for offences against the Opium Act.[14]
This situation was unacceptable for the Minister of Justice. In collaboration with the Health Minister he sent a memorandum to parliament about Compulsion and Pressure in the Treatment of Addicts[15].
No new legal proposals were made but both the judiciary and the treatment system were urged to make more creative use of the existing legal possibilities to put pressure upon addicts to undergo treatment as an alternative for imprisonment.
Involuntary treatment is not possible in the Netherlands. Although the Government stresses the importance of the treatment alternative the Ministry of Justice seeks to develop treatment facilities in special wards within the prison system as well. To my mind, such facilities are an undesirable and confusing mixture of punishment and treament.

Some data

Reliable estimates on the number of drug addicts in the Netherlands vary between 15,000 and 20,000 out of the total Dutch population of 14.5 million; although the size of the overall problem appears to be stabilising and in some cities to be decreasing, treatment staff suggest more mental disorders among addicts.

Over the years drug abuse seems to have increased among groups with a relatively disadvantaged social and economic background (ethnic minorities).

Estimates about the number of drug addicts in Amsterdam, the biggest city of the country, vary from 4,000 to 7,000 (population: 640,000).

To give an indication for heroin use: prevalence of heroin use in Amsterdam is estimated at 0.4 per cent (household survey among 12 years and older; 1987)[5].

The use of cocaine has stabilized; "crack" use is a rarity. Prevalence of cocaine use in Amsterdam has been put at 0.6 per cent (12 years and older; 1987)[5]. The highest (last month-)prevalence (1.7%) was found in the age bracket between 25 and 29 years.

A study carried out by Cohen on cocaine use in Amsterdam in non deviant subcultures shows that the average age of users is 30 years and the age on which people start is 22 years. About 50 per cent of the cocaine users never use more than half a gram a week. The users do not underestimate the negative effects, which mainly occur at a level of use of 2.5 gram a week.

86.2 per cent of the users reported to have stopped for more than a month, against 11.9 per cent who never did since they started cocaine use. Since the use is embedded in a social setting, without any marginalization, some limiting rules have been developed.

Many heroin users do not restrict their use to heroin but combine various substances, including alcohol and psychotropic substances, such as benzodiazepines.

The average age of users is rising (in Amsterdam from 26.8 to 30.1 years between 1981 and 1987) and people who take drugs for the first time tend to be older. In Amsterdam the proportion of drug users of 21 years and younger continues to decrease: from 14.4 per cent in 1981 to 4.8 per cent in 1987[11].

In spite of the wide availability of medically prescribed methadone (to 6300 addicts in the Netherlands on Jan. 11, 1988, an average day) there has never been so many drug addicts asking for detoxification and drug free treatment as at present. In Amsterdam this number doubled between 1981 and 1986[11].

Conclusion

In this paper I have outlined the dilemma of creating new problems while solving others. I realize that some people will also feel that there is a dilemma in setting the limits between being realistic and being indulgent in treatment. To my mind these dilemmas can only be dealt with in an open exchange of ideas. Critical questions on drug policies should be asked over and over again.

References

1. KORTHALS ALTES, F. (Minister of Justice) (1987) Drug policy in The Netherlands. Presented at the International Conference on Drug Abuse and Illicit Trafficking (Vienna: United Nations), p. 1.

2. NARCOTICS WORKING PARTY (1972) Backgrounds And Risks of Drug Use, (The Hague: Government Publishing Office).

3. CAPELLE, van M.A.A. (1988) Het Nederlandse drugsbeleid in hoofdlijnen. Algemeen Politieblad van het Koninkrijk der Nederlanden, 137, 291-297 (Outlines of Dutch drug policy, Dutch Police Gazette).

4. WAL, van der H.J. (1985) Roken, drinken, cannabisgebruik, p. 57. (Smoking, drinking and cannabis use) (Amsterdam: SWOAD).

5. SANDWIJK, P., WESTERTERP, I. and MUSTERD, S. (1988) Het gebruik van legale en illegale drugs in Amsterdam (Thse use of legal and illegal drugs in Amsterdam) (Amsterdam: Universiteit van Amsterdam, Instituut Sociale Geografie).

6. COMPREHENSIVE MULTIDISCIPLINARY OUTLINE OF FUTURE ACTIVITIES IN DRUGS ABUSE CONTROL (1987). In: International Conference on Drug Abuse and Illicit Trafficking, A/CONF.133/12, pp. 31, 32 and 51-71 (Vienna: United Nations).

7. ENGELSMAN, E.L. (1986) Drug policy: is the cure worse than the disease? To a process of normalization of drug problems. Presented at the 15th ICAA International Institute on prevention and treatment of drug dependence, Amsterdam/Noordwijkerhout.

8. INTERDEPARTEMENTALE STUURGROEP ALCOHOL- EN DRUGBELEID (1985) Drugbeleid in beweging, naar een normalisering van de drugproblematiek (Interministerial Steering Group on Alcohol and Drugs Misuse Policy; Drugpolicy in motion: towards a normalization of drug problems). (The Hague: State Publishers).

9. AID TO DRUG ADDICTS (1981) Letter from the State Secretary for Health and Environmental Protection to the Speaker of the Lower House of the States General (Leidschendam: Tweede Kamer 16680).

10. KAPLAN, C.D. and VRIES, M. de (1988) Protecting Factors. Addiction Research Institute, Medical Faculty, Erasmus University Rotterdam (Rotterdam).

11. BUNING, E.C. (1986, 1987) De GG en GD en het drugprobleem in cijfers (The municipal health service and the drug problem in figures) (Amsterdam: Municipal Health Service).
    BUNING, E.C. and BRUSSEL, G.H.A. van (1988) Combatting Aids among intravenous drug users in Amsterdam. Presented for the Ad hoc Group AIDS of the European Community, Brussels; Publication of the Amsterdam Municipal Health Service.

12. BUNING, E.C. and BRUSSEL, G.H.A. van (1988) Stemming the Aids epidemic among intravenous drug users. Presented at the Third National Conference and Aids, Hobart, Australia.

13. HOUWELING, H. (1987) Epidemiologie van Aids en HIV-infecties in Nederland; huidige situatie en prognose voor de periode 1987-1990. Nederlands Tijdschrift Geneeskunde, 131, 818-824 (Epidemiology of Aids and HIV-infections in the Netherlands; present situation and prognosis for 1987-1990. Dutch Medical Journal).

14. ERKELENS, L.H. (1987) Drug developments in the Dutch Probation and Prison Organizations. Presented at the INTRES CONFERENCE, January, Barcelona.

15. DWANG EN DRANG IN DE HULPVERLENING AAN VERSLAAFDEN (1988) (Compulsion and pressure in treatment to addicts) Letter from the Minister of Justice and Minister of Health to the Speaker of the Lower House of the States General (Rijswijk, Tweede Kamer 20415).

16. COHEN, P. (1988). Cocaine use in Amsterdam in non deviant subcultures, University of Amsterdam (Amsterdam).

THE MERSEY HARM-REDUCTION MODEL :
A STRATEGY FOR DEALING WITH DRUG USERS

Presentation at the
International Conference on Drug Policy Reform,
Bethesda, Maryland, U.S.A.
22nd October 1988

by

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ABSTRACT

This paper describes a general drug policy which has been developed in Merseyside, England since the mid-80s, in order to deal with the harmful consequences of a large and growing population of people who use prohibited drugs. The first and fundamental principle of the model is that abstinence from drugs should not be the only objective of services to drug users, because it excludes a substantial proportion of people who are committed to a lifestyle of long-term drug use. This leads to the second principle: abstinence should be conceptualized as the final goal in a series of harm-reduction objectives. The third principle is that the most effective way of getting people to minimize the harmful effects of their drug use is to provide user-friendly services which attract them into contact and empower them to change their behaviour toward a suitable intermediate objective. The Mersey model of harm-reduction is being applied in four areas of services to drug users - treatment, care, control and education - and initial evidence of effectiveness is encouraging. In order to illustrate the Mersey harm reduction model in action, an account of the policies and practices of the Liverpool syringe exchange scheme is given.

1. DRUG USE IN MERSEYSIDE

There has been a major increase in the prevalence of nearly all forms of drug use in Britain during the 1980s. Along with London and Glasgow, Merseyside has witnessed the highest levels of illicit drug use ever recorded in Britain. Merseyside, situated in the the North-West of England, consists of the city of Liverpool and the four boroughs of Wirral, Sefton, St. Helens and Knowsley, and has a population of 1.4 million. The mass media have particularly highlighted the region's "heroin epidemic", with the most affected area being labelled "Smack City". Local research (eg. Parker et al., 1988; Fazey, 1988), combined with official figures for drug convictions and addict notifications, suggest a conservative estimate of about 15,000 regular heroin users during 1987, up to 40% of whom are believed to be drug injectors. A number of surveys of 15-to-20 year olds have consistently found that about one in four people in this age-group has tried illicit drugs, and about one in ten is a regular user, usually of cannabis (Parker et al., 1988; Newcombe & O'Hare, 1988).

Although this surge in the prevalence of drug-taking has been attributed by many to the mass unemployment and widespread poverty that Merseyside and other British cities have experienced in the 1980s, research has confirmed this hypothesis only in the case of heroin (eg. Parker et al., 1987; Fazey, 1988). The use of the other popular illicit drugs - cannabis, amphetamine, magic mushrooms, LSD and solvents - appears to cut across class barriers, and has increased despite a strong prohibition policy involving police clampdowns, detoxification and counselling services, stiffer sentencing by the courts, drug education programmes in schools, and anti-drug campaigns in the local press. This "paradox" led many local drug service practitioners and researchers to conclude that a "war on drugs" is an ineffective strategy for reducing drug use or drug problems (eg. Marks, 1987; Newcombe, 1986). Combined with soaring levels of drug-related crime (Fazey, 1988; Parker & Newcombe, 1987) and the first signs of HIV infection in the Merseyside population, this provided the backdrop for a change in strategy which continues to spread through drug services in Merseyside.

2. THE THEORY OF HARM-REDUCTION

The principles and practices underlying the strategy of social intervention evolving in Merseyside have become known as harm-reduction. The harm-reduction approach to drug users is based on a multi-disciplinary framework rather than the narrow confines of the medical or criminological models. It has been spearheaded by Mersey Regional Health Authority's Drug Information Centre and AIDS Prevention Unit, though would not have been possible without the unprecedented cooperation between district health authorities, the police, drug education coordinators, and other services whose clients comprise or include drug users.

The first and fundamental principle of the harm-reduction model is that abstinence from drugs - preventing people from starting to use and getting current users to stop taking drugs - should not be the only objective of services to drug users, because it excludes a substantial proportion of people who are committed to a lifestyle of long-term drug use. This leads to the second principle: abstinence should be conceptualized as the top goal in a hierarchy of harm-reduction objectives (like a series of safety nets). That is, if some people will not abstain from drug use, then the next best step is not to banish them to the black market and the drug sub-culture, but to minimize the harmful consequences of their drug-taking behaviour, both for the individual, the community, and society as a whole. The third principle is that the most effective way of getting people to minimize the harmful effects of their drug use is to provide user-friendly services which attract them into contact and empower them to change their behaviour toward a suitable intermediate objective. This means services which are accessible, confidential, informal and relevant (client-led). This model is an abstract description of the shared policies of several agencies in Merseyside, though there is not yet a unified approach involving all drug-related services, and several agencies are still concerned exclusively with achieving abstention from drugs.

Nevertheless, this harm-reduction model has now been explicitly identified by the British Government's Advisory Council on the Misuse of Drugs as a strategy for dealing with actual and potential drug injectors (DHSS, 1988). For instance, when harm reduction objectives are ranked according to cost-benefit priorities, it is clear that HIV/AIDS prevention takes priority over prevention of drug use, because it presents a greater threat to the drug user, to public health and to the national economy. Thus, if a drug injector will not abstain, he or she must be encouraged toward non-injectable drug use, or else not to share injection equipment, or, as a last resort, to clean equipment before re-using it. Methods for achieving such behaviour-change objectives include the long-term prescription of methadone, the provision of syringe exchange facilities, and education about equipment cleaning procedures. Furthermore, if the proportion of drug injectors attracted into contact with these services is to be maximised, they must offer more than an anti-HIV facility. In particular, committed drug injectors who do not perceive themselves to be at risk of HIV infection are more likely to be attracted to a service which also offers advice on safer drug use and provides injecting accessories (eg. tourniquets, sterile water, swabs).

3. THE PRACTICE OF HARM-REDUCTION

The harm-reduction strategy is being developed in four areas of services to drug users (though many agencies remain or have relapsed back into being single-mindedly abstentionist): treatment, care, control, and education.

1. Treatment: a small number of local GPs and consultant psychiatrists provide a flexible range of treatment options which recognize the various needs of different types of drug user, eg. non-drug therapy, methadone detoxification, and maintenance on oral or injectable drugs (including heroin). However, the Liverpool Drug Dependency Unit, which was known nationally for its' flexible treatment policy up to 1987, is currently closed to new clients and is considering phasing out maintenance and the prescription of injectable drugs - despite the fact that local research has demonstrated a reduction in crime associated with attendance at such treatment services (Fazey, 1988; Jarvis & Parker, 1988).

2. Care and support: a regional health care service prioritizing drug injectors and prostitutes was opened at the Maryland Centre in central Liverpool in May 1988. This service provides a syringe exchange facility, condoms and injection accessories, information on safer drug use, HIV testing, general advice, counselling, and referrals. Several local pharmacists also provide syringes to injectors, and some also take back used injection equipment. Several drop-in centres, ten syringe exchange schemes, and a team of outreach workers have formed a new wave of front-line drug services in Merseyside (see, eg., McDermott, 1988). Professionals in generic services in the region - including youth workers, education coordinators and probation officers - have also begun to operate a harm-reduction approach toward young people using drugs (see, eg., Clements et al., 1988). Sefton Probation Drugs Team and Wirral Youth Service have produced policy documents based on a harm-reduction philosophy.

3. Control: Merseyside police now caution people for first offence of possession of any drug (if cooperative), and have a policy of focussing on suppliers. They also cooperate with the syringe exchange scheme by not operating in the area of the scheme, giving leaflets on the scheme to arrested injectors, and giving injectors receipts for any syringes confiscated. However, the sentencing policy of local courts toward drug users remains draconian, and custodial institutions have nothing to offer drug users but "cold turkey" and increased risk of HIV infection.

4. Education: the Drug Education Research Project is researching the nature and extent of drug use in Merseyside, and producing drug education resources for determined drug users and those who work with them. The research has found high levels of illicit drug use combined with poor practical knowledge of risk reduction (Newcombe & O'Hare, 1988). The resources being developed utilize popular culture media - including cartoons, games, promotional devices and drug paraphernalia - to

communicate harm-reduction messages, and will soon be implemented and evaluated (Newcombe, 1988b). A journal (Mersey Drugs Journal) is being produced to inform professionals about drug policy and harm-reduction issues, and a manual of guidelines and a training programme for harm-reduction practitioners are being developed. Education of the general public is a neglected area, though work with the local press appears to have resulted in a reduction in sensationalist reporting.

4. THE LIVERPOOL SYRINGE EXCHANGE SCHEME

In order to illustrate the Mersey harm reduction model in action, a brief account of the policies and practices of the Liverpool syringe exchange scheme will be presented. The scheme opened in October 1986, and expanded into a regional health care service for drug injectors and prostitutes in May 1988, since when it has been based at the Maryland Centre in central Liverpool. The service is open to everyone, though clients requiring injection equipment have to show their injection sites as evidence that they are already injecting. The main purpose of the health care service is to prevent the contraction and transmission of HIV infection by drug injectors and prostitutes, although the more general aim is to reduce all forms of harm that they experience or cause. The specific objectives regarding HIV prevention include reducing the sharing of injection equipment by providing syringe barrels and needles on an exchange (new-for-old) basis, and reducing high-risk sexual activities (eg. by the provision of free condoms and safer sex literature). The service also offers confidential HIV testing and counselling. The more general objectives include promoting safer drug use, providing sterile injecting accessories, increasing service contacts and health check-ups, and reducing social, legal and health problems (see Parry, 1987; Carr & Dalton, 1988).

The staff involved in the service include a Nurse Practitioner, who manages and operates the service; a full-time Health Promotion Officer, who assists the Nurse; a full-time researcher and fieldwork supervisor; a part-time outreach worker with female prostitutes; a sessional outreach worker with male prostitutes; a part-time outreach worker with drug injectors; and, a full-time receptionist. The service has been developed and is guided by the Regional Drugs/AIDS Coordinator, and additional support is available from other staff based in the Maryland Centre, including a secretary and an administrator. There are also plans to employ a clinical medical officer on a sessional basis. The bringing together of these services and professionals in the same premises, next door to the Drug Information Centre, and very close to both the local Drug Dependency Unit and the Drug Counselling Service, has provided an ideal setting for the coordination of HIV/drug services.

SERVICE DELIVERY. Staff at the Maryland Centre feel that the success of the scheme in attracting drug injectors from "underground" is strongly related to the style of service delivery, which has become known as "user-friendliness". This "consumer-oriented" approach, which is the hallmark of the Liverpool scheme, is clearly lacking in many services which deal with drug users, and may explain why local research has found that the majority of heroin users and other drug-takers are not known to official agencies (Parker et al., 1988). Providing a user-friendly service is based on the belief that many drug injectors will not be attracted into contact by the offer of a syringe "swop shop" alone, and that others will not remain in contact for long if they are dissatisfied with confidentiality or staff. In particular, user-friendliness involves:

1. Location within an agency with a relatively good reputation among people involved in illicit drug-taking and sexual activities - basing services in agencies with a strong moralistic orientation or with an "official" atmosphere may discourage attendance.
2. Premises which provide both anonymity and general accessibility, such as a side-street in the city centre - a service based in premises in a residential area may be met with hostility from local residents, and clients may feel conspicuous when entering them, leading to a higher drop-out rate.
3. Effective advertising through leaflets and posters in the local press, pharmacies, and agencies which deal with drug users; and, making full use of outreach workers and the drug users' "grapevine"
4. Extensive cooperation from management bodies and from medical, voluntary and socio-legal agencies, particularly the police (eg. agreement not to conduct surveillance on the service premises) - lack of cooperation from the police will effectively close down a syringe exchange scheme.
5. Open-door approach: allowing any drug injector or prostitute to walk in off the street and use the service, including under-16s, drug dealers, and non-residents.
6. Long opening hours: since many drug injectors and prostitutes are known to operate according to a time-scale which starts around the middle of the day and finishes in the small hours of the night, services should ideally be open on at least some evenings (eg. up to 9 p.m.), and weekends as well as weekdays.
7. Short waiting times: because of the 'busy' lifestyle of drug injectors and prostitutes, and their ambivalence about approaching official agencies, sufficient staff should be available at relevant times to avoid keeping clients waiting longer than a few minutes.
8. Confidential, anonymous service: given that many clients will have taken the risk of contacting an official agency for the first time, it is crucial to allow anonymity, and to ask the minimum number of questions possible until a relationship has been built up with the client. Access to scheme records should be restricted to staff and researchers.
9. Friendly, experienced, non-authoritarian staff: a non-judgmental attitude is essential - this means accepting that many (if not most)

clients have made a rational choice about their drug use and lifestyle, and so not attempting to coerce them into abstinence, unless this is requested. Having ex-users (or people from similar backgrounds to the clients) on the staff is usually helpful.

10. Flexible attendance and syringe exchange arrangements: clients should be allowed to attend on an irregular basis without appointments, and equipment loans and returns should be balanced over time rather than per visit. This is because many clients live a more disorganized lifestyle than non-users, and some will be exchanging syringes for acquaintances (eg. dealers), and so may not always have their used "works" with them when they visit the scheme. However, the eventual return of all used equipment should be encouraged, to prevent needlestick injuries occurring.

11. Providing a wide variety of free services and useful products. Products should include a range of syringe barrels and needles of different sizes; other injecting accessories, such as swabs, tourniquets, closure strips, and sterile water; condoms and spermicides; and, leaflets on safer sex and safer drug use. Services should include advice on safer injecting, particularly site rotation, injection technique and femoral vein injecting; advice on safer drug use and safer sex; advice on health and socio-legal problems; voluntary HIV tests and counselling; and referrals to other agencies.

EFFECTIVENESS. A formal research programme on the Mersey region's syringe exchange schemes and outreach work begins in November 1988, though routine monitoring of exchange records and client characterisics has been conducted since the scheme opened in October 1986. The Liverpool scheme is also part of the government funded research on 15 "experimental" syringe exchange schemes, which has involved interviews with clients of exchange schemes, and which has found evidence of a general reduction in equipment sharing among drug injectors attending the schemes (see Stimson et al., 1987, 1988).

The HIV prevention objective of the Liverpool scheme has so far been evaluated according to five criteria:

1. Does it attract drug injectors into contact?

Between October 1986 and June 1988 the Liverpool exchange scheme was attended by over 1,000 drug injectors - far more than any other drug agency in Merseyside. At the time of contact, only a third were known to be in contact with treatment agencies (84% were male, and the average age was 25 years). New clients continue to arrive at a rate of about 60 per month. Somewhere between 500 and 1000 drug injectors are also known to other syringe exchange agencies in the region. However, since there are an estimated 6,000 drug injectors in the region, plans are being developed to reach into the remaining "hidden sector", particularly into such under-represented groups as women, teenagers and ethnic groups. What proportion of clients maintain contact or "drop out" is difficult to estimate when regular attendance is not required.

2. Is a balanced exchange of syringes achieved?
If clients do not return used injecting equipment, there is no guarantee that it will not be re-used or else be improperly discarded (creating a health hazard to the community). Between October 1986 and June 1988, 1,050 clients were issued a total of 94,000 syringes, and had returned a total of about 84,000 syringes. Since over 20,000 syringes were still "on loan" to clients at this time, this clearly demonstrates that a fair exchange of equipment was being achieved. To date, there have been no needlestick injuries to staff, and no incidents of violence.

3. Is the sharing of injection equipment reduced?
Analysis of 58 interviews with Liverpool scheme clients, conducted as part of the national research programme, shows that although 48% stated that they had shared injection equipment during the past year, only 19% stated that they had shared equipment in the past four weeks. Furthermore, the typical past-month sharer reported sharing equipment only once or twice, with one or two friends. Similarly, analysis of the intake sheets of 129 clients revealed that 82% reported no sharing of syringes in the past four weeks.

4. Is there a reduction in unsafe sex?
Limited information is so far available about clients' sexual behaviour. Almost two-thirds (64%) of the 58 clients interviewed stated that they had had only one sexual partner during the past three months, and 21% stated that they had had no sexual partners during this time. The remaining 15% admitted to between two and seven sexual partners during the past three months, though none stated that they had been involved in prostitution. However, encouragement to use condoms has met with less success: only 14% stated that they ever used a condom with a regular partner, and only 6% stated that they ever used a condom with a casual sexual partner.

5. Is a low level of HIV infection being achieved?
The ultimate criterion of effectiveness concerns how many drug injectors are prevented from becoming infected with HIV. Of the 40 clients who have been tested to date, none have been HIV seropositive. All of the 12 seropositive injectors who had been identified by March 1988 in the Mersey region appear to have been infected outside of the area. Merseyside continues to have one of the lowest levels of HIV infection among drug injectors in Britain. However, at least 100 drug injectors in the region are believed to have shared syringes with HIV-positive users, and so there is no room for complacency.

Research over the next three years will focus on factors related to behaviour change among drug injectors, the effects of educational interventions, the reasons for non-attendance and dropping out of syringe exchange schemes, testing of returned syringes for HIV antibodies, the preventive value of the auto-destruct (one-use) syringe, and the wider harm-reduction effects of syringe exchange schemes.

6. CONCLUSION

Initial evidence indicates that the Mersey harm-reduction strategy is an effective policy for preventing some of the more harmful consequences of drug-taking, such as the spread of dangerous viruses and acquisitive crime. The effects of this policy on the prevalence of various other kinds of drug-related harm - such as overdosing, physical disease, mental disorder, family distress, violence, traffic accidents, and the cost of drug services - remains to be explored. However, it is its' apparent effectiveness as an AIDS prevention strategy, particularly through the medium of syringe exchange schemes, that makes the harm-reduction policy such a rational and peaceful (rather than reactive and war-like) response to illicit drug use. As the British government's Advisory Council on the Misuse of Drugs have concluded, "the spread of HIV is a greater danger to individual and public health than drug misuse ... We must therefore be prepared to work with those who continue to misuse drugs to help them reduce the risks involved in doing so" (1988, p.17).

POSTSCRIPT: In September 1988, the British government acknowledged the evidence from the national research on syringe exchange schemes that "drug misusers are willing and able to change their behaviour away from risky practices", and allocated an extra three million pounds to the development of these HIV prevention services. It also issued guidelines on setting up syringe exchange schemes, "based on the principles underlying our experimental schemes" (Department of Health, 1988).

REFERENCES

Carr, J. & Dalton, S. (1988). Syringe Exchange: the Liverpool experience. Druglink, 3 (3), 12-14.

Clements, I., Cohen, J. & O'Hare, P. (1988). Beyond 'Just Say No'. Druglink, 3 (3), 8-9.

Department of Health (1988). Three million pounds additional funding to prevent the spread of AIDS among drug users; and, guidance on setting up syringe exchange schemes for drug misusers. September, 27, 1988. London: Dept. Health.

DHSS (1988). AIDS and Drug Misuse Part I: A Report by The Advisory Council on the Misuse of Drugs. London: HMSO.

Fazey, C. (1988). An evaluation of the Liverpool Drug Dependency Clinic: the first two years, 1985 to 1987. Liverpool: Research, Evalution and Data Analysis.

Marks, J. (1987). The paradox of prohibition. Mersey Drugs Journal, 1 (1), 6-7.

McDermott, P. (1988). Drug Injectors in the Chester Area. Liverpool: AIDS Prevention Unit.

Newcombe, R. (1986). High time for harm reduction. Liverpool: Drug Information Centre (summarized in Druglink, 1987, 2 (1), 10-11).

Newcombe, R. (1988a). The Liverpool syringe exchange scheme for drug injectors: initial evidence of effectiveness in HIV prevention. Paper presented at the First International Conference on the Global Impact of AIDS, Barbican Centre, London (March, 1988).

Newcombe, R. (1988b). Drug education through popular culture. Druglink, 3 (5).

Newcombe, R. & O'Hare, P. (1988). A survey of drug use among young people in South Sefton, Merseyside. Liverpool: Drug Information Centre.

Parker, H. & Newcombe, R. (1987). Heroin use and acquisitive crime in an English community. British Journal of Sociology, 38, 331-350.

Parker, H., Bakx, K. & Newcombe, R. (1988). Living with Heroin: the impact of a drugs "epidemic" on an English community. Milton Keynes: Open University Books.

Parker, H., Newcombe, R. & Bakx, K. (1987). The new heroin users: prevalence and characteristics in Wirral, Merseyside. British Journal of Addiction, 82, 165-175.

Parry, A. (1987). Needle swop in Mersey. Druglink, 2, p.7.

Stimson, G. et al. (1988). Injecting equipment exchange schemes: a preliminary report on research. Monitoring Research Group, Goldsmiths' College, University of London.

City of Annapolis

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DENNIS CALLAHAN
Mayor

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November 9, 1988

The Honorable Charles B. Rangel
Chairman, Select Committee on Narcotics Abuse and Control
U.S. House of Representatives
Room H2-234, House Office Building Annex 2
Washington, D.C. 20515-6425

Dear Mr. Chairman

Once again, I want to thank you and the other members of your Select Committee for the opportunity to express my views before you in late September. The work being undertaken by your committee is important to the future of this nation, and I commend you for it.

I would like to respond to Congressman James Scheuer's question:

"Could you please tell us about your city's ability to provide comprehensive treatment and rehabilitation?"

First, the City of Annapolis has a policy regarding City Employee Substance Abuse Treatment and Rehabilitation Services as follows:

The City offers an Employee Assistance Program (EAP) to all employees for evaluation, counseling and/or referral to treatment. Employees may be self-referred for evaluation or referred by the employee's supervisor through the Personnel Department. The City pays for the first three visits to the evaluating agency. The agency determines the extent of the problem and whether the employee can be treated in-house, needs out-patient treatment by another agency or should be admitted to an in-patient treatment and rehabilitation facility.

The employee is covered under the City's group health insurance policy which contains specific and separate riders for alcoholism treatment and Drug Abuse Rehabilitation/Treatment.

The City provides these services to encourage employees needing treatment to seek rehabilitation and resume their lives as productive workers and citizens.

Secondly, I am pleased to enclose a copy of the REPORT OF THE

INTENTIONAL
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MAYOR'S TASK FORCE FOR THE PREVENTION OF SUBSTANCE ABUSE which was released in October shortly after my appearance before your committee.

Specifically, I would call attention to pages 6 through and including 14 of the report which deals with the community resources for treatment and counseling.

Thank you for your continued interest and your efforts to take positive steps to rid our nation of the menace of illicit drug abuse.

With warm personal regards,

Dennis Callahan
Mayor

DC/twr

Encl

NOV 4 1988

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October 31, 1988

The Honorable Dennis Callahan
Mayor
City of Annapolis
Municipal Building
160 Duke of Gloucester Street
Annapolis, Maryland 21401

Dear Mayor Callahan:

Enclosed is a question that a Member of the Select Committee, Representative James Scheuer, would like to have answered regarding the September 29-30, 1988 legalization hearing that you participated in.

As I mentioned during the hearing, the record will be left open to allow Members the opportunity to obtain further information from witnesses.

I appreciate your cooperation and quick response.

Sincerely,

Charles B Rangel

CHARLES B. RANGEL
Chairman

Enclosure

QUESTION FOR MAYORS

1) Could you please tell us about your city's ability to provide comprehensive treatment and rehabilitation?

REPORT

OF

THE MAYOR'S TASK FORCE FOR THE PREVENTION OF SUBSTANCE ABUSE

ANNAPOLIS, MARYLAND

OCTOBER 1988

OVERVIEW

This ancient city faces one of greatest crises in its almost 350 year history. It is a crisis faced by our entire nation. That crisis is the very real prospect of our society and civilization being unraveled by a population addicted to drugs and alcohol. The monetary cost is enormous. Loss of productivity and the strain on public and private services reaches into the billions of dollars if not beyond. But more important are the social costs. The very fabric of our families and communities is being torn apart.

Our way of life is being undermined by the drug lords and cartels of foreign nations as no enemy has ever been able to do. Many foreign governments have been subverted by the vast wealth and threats of drug traffickers. One must wonder how long our political institutions can remain immune.

The death and destruction from the abuse of drugs and alcohol are all around us. Anyone who thinks the drug and alcohol problem doesn't affect them, need only look at their insurance bills to see the cost of treating addicts and compensating the innocent victims of addicts. They need only look to their homes, vehicles, and businesses, or those of their neighbors, which have been broken into to obtain the wherewithal to buy drugs. They need only consider the dangers created in industry and transportation by impaired and dysfunctioning operators. It affects everyone. No one is immune. This is the unfortunate condition in which the Mayor's Task Force for the Prevention Substance Abuse has found our beloved City during this long hot summer of 1988.

That conclusion, however, is not one of pessimism for the future. There is also clear evidence of a grass-roots awakening of concern among the citizens of Annapolis. There seems to be less acceptance of drugs and drug users and sellers than there has been over the last twenty years while we were in our downhill slide. The communities want it out and they want it out now. Many public and private groups and organizations have been catalyzed by this developing awareness and are becoming more involved.

The Mayor's Task Force for the Prevention of Substance Abuse was formed on April 19, 1988. The objectives of the Task Force were broad and far-reaching. They were as follows:

1. aggressive law enforcement;

2. public education and awareness;

3. counselling and other rehabilitation resources development;

4. networking of existing agencies and governmental authorities in order to form a coordinated substance abuse informational resource; and

5. elimination of public complacency and apathy towards the problem.

The first course of action decided upon by the Task Force was to hold public hearings at which groups and organizations involved in counselling, treatment and education, as well as citizens, would be invited to come forward and express their thoughts, concerns, and ideas relating to substance abuse. It was felt that the Task Force needed more than just its own thoughts and perceptions. Everyone needed to be heard from.

The hearings were held at Eastport Elementary School on May 24, 1988, the Stanton Community Center on May 26, 1988, and the Annapolis Junior High School on June 1, 1988. Attendance and opinions were varied but one messsage came across loud and clear. When the public was asked what they thought should be done about the drug problem, the answer was inevitably the same - anything that is necessary. A large portion of the public just does not want to tolerate or live with the problem any longer.

As the Task Force met and discussed these issues over the months, it has become clear how important these hearings were. They were the touchstone that was always gone back to when there was a need for guidance. Many of the public responses at these hearings will be referred to later in this report.

After the public hearings, the Task Force met each week to evaluate what was being done, what was available, and what could or should be done to combat substance abuse. The term substance abuse covers a broad area. There are illegal drugs, legally prescribed drugs, and over the counter drugs, all of which can be abused. Alcohol is legal, but is used immoderately and abused. Its use is prohibited for minors and has no place in the transportation system or work place. Alcohol is a drug and where appropriate within the context of this report, the term drug includes the use of alcohol.

At these weekly meetings the Task Force discussed the problem with individuals fighting the war on drugs at all levels. Persons involved in law enforcement, government, treatment, prevention, education, counselling, and many others gave very graciously of their time and shared with the Task Force their thoughts, views, experience, and recommendations. This report is an embodiment of those thoughtful comments which we received.

At the public hearings, the suggestion was made that the Task Force could not be successful in assessing the problem unless it went into the affected communities and saw the problem first hand. The point was made that the situation cannot be seen or experienced from offices or public hearings.

Since those hearings, the members of the Task Force have attended community meetings and rallys and have benefitted from the experience. On June 20, 1988, the entire Task Force visited the Boston Heights housing complex, one of the hardest hit by the drug problem. Going door-to-door throughout the entire community, distributing pamphlets, a hotline number, and talking to as many residents as possible, the devastation caused by drug abuse became very real.

It is with this background that the Task Force makes its report and recommendations. Many may not agree with all of the findings and conclusions. It is hoped, however, that this first evaluation of the substance abuse crisis in the City of Annapolis might provide a foundation on which others can build.

At about the same time the Task Force was formed, a theory for dealing with the drug problem began to be proposed which in the Task Force's view has thrown a monkey wrench into the war on drugs. The theory is that the war has been lost and that drug use should be decriminalized in order to reduce criminal activity. As a practical matter, that theory found less than a handful of supporters at our public hearings, no support from professionals we met with involved in the problem and no support on the Task Force.

As a philosophical proposition the theory is dangerous and sends the wrong message to the community. It makes no sense to talk about surrender until the war has been fought. The difficult battles in that war are still ahead. National, state, and local governments have yet to put the necessary resources into the struggle.

The government spends millions on testing, evaluating, and regulating prescription drugs. Allowing the use of dangerous drugs that have no medical purpose is to surrender one of the basic obligations of government to the people; to provide for their health and welfare.

Even proponents of decriminalization do not recommend the free use of such dangerous hallucinogenic drugs as PCP and

LSD. How would the criminal element be eliminated when there would still be a black market for these and other illegal drugs? Prices would remain high and there would still be a need for criminal activity to purchase them.

What would happen to the safety and productivity of the community if we allowed our population of addicts to grow even larger? Who would pay for the rehabilitation and care of these addicts? Who would support the addicts who can't function and would have to resort to crime to meet basic necessities?

In short, the answer to the proposal of decriminalization of drugs is all the unanswerable and unsolvable questions it raises. The unfortunate aspect of this controvery is that it diverts attention from the important task ahead; the return to a normally functioning drug-free society.

Another controversial area which was discussed dealt with drug testing. Our nation is one in which personal freedom is held in very high regard. Many view mandatory drug testing as an infringement on those very cherished liberties. On the other hand, everyone in this nation also recognizes that in a time of crisis, personal sacrifices must be made. This is such a crisis.

If one were living alone on an island, what he or she does is probably no one elses business. But, when one lives in a society facing the crisis that our's does, there are certain obligations, especially when that individual is seeking a privilege from the community. If an individual wants to operate a multi-ton vehicle on the highways and rails or in the air or water, then he must guarantee to society that he will be drug-free. If an individual seeks employment, especially in the areas of public safety, health, and security, in either industry or government, he must guarantee to his employer and co-worker that he will be drug-free in the work place. The privilege of engaging in organized public sporting events should also require such a guarantee to fellow players and spectators, especially the young. Drug testing is one way to make that guarantee a reality. Progressive industries are now routinely requiring a pre-employment agreement to random drug testing as a condition of employment.

Where not infringing upon any constitutionally guaranteed rights, such testing, where appropriate, is an unfortunate necessity in the crisis being faced. Such sacrifices now may lead to a day when drug testing of the community is only something read about in history books.

The disciplines and agencies involved in combating the substance abuse problem can be analyzed and categorized in many ways. This report attempts to deal with them in the manner felt to be appropriate to the Annapolis experience. The areas to be discussed deal with treatment and counselling, schools, law enforcement, and prevention.

TREATMENT AND COUNSELING

It has been said to the Task Force more than once that we may have lost a generation to drug and alcohol addiction. Over 23 million Americans age 12 and over currently use illicit drugs. The last twenty years has seen a slow slide into the crisis that confronts us today. We are, however, moving from an era in which drug use was considered recreational and conciousness raising to the realization that our society is carrying an immense population of addicts of both drugs and alcohol. The costs, to our health, safety and productivity, as discussed before, is enormous.

For those addicted and without the ability to abstain, the choice is a simple one though hard to make. If treatment and counselling is not sought, then death is inevitable. The toll on the human body from continued and chronic drug and alcohol abuse is well-documented. The psychological processess that permit an addict to ignore that process and pursue the drug of choice until death is less understood. AIDS is another of the deadly consequences of drug abuse. Intravenous drug users account for 25 percent of all AIDS patients. It is for the substance abuser that treatment and counselling play their role in the war on drugs.

The number of treatment and counselling organizations and facilities available to Annapolitans are in some areas quite impressive and in others are stretched very thin. As might be expected, those stretched the farthest are those requiring the most financial assistance, whether it be public or private.

Although treatment and counselling play a vital role in helping an addict or alcoholic recover, it is universally recognized that it is up to the individual to cure himself. No one can recover against his will. For that reason, it is felt that the large number of diverse organizations and philosophies of recovery may be appropriate. A program or organization that is effective for one individual may not work for another. A long inpatient program may be necessary for some but not all. Whether strict discipline or patience and understanding is appropriate depends on the individual. No suggestion, therefore, is made or implied that any organization or facility discussed is more or less meritorious of consideration where help is needed. If it works then it's worthwhile.

The Open Door is one of the basic providers of services in Annapolis. Having a staff of fifty working in four offices throughout the county, over 54% of Open Door clients are from Annapolis. Offering counselling, urinalysis and methodone treatment, the continued existence of the Open Door in Annapolis is important to the City. The methodone program for the treatment of drug addiction does appear to be a controversial issue. That issue is one which must be resolved within the medical community and is far beyond the expertise of the Task Force. With inadequate facilities on Cathedral Street and no parking for staff or clients in the area, consideration is being given to moving to another area. It is clear that the large number of clients from Annapolis is due to the easy accessability of the facility. The Open Door should be encouraged, by whatever means possible, to maintain that availability to the Annapolis area.

There is also a recognized need for a detoxification facility in the Annapolis area. The Anne Arundel General Hospital does not have such a unit at the present time. If the Open Door, which is across the street from the hosptial, wishes to place an individual in such a program, he or she must be sent to North Arundel Hospital near Glen Burnie. There is some question as to whether a detoxification program developed for alcoholism is any longer appropriate in light of growing polydrug use requiring longer and more complex detoxification. A recognized need for such a service in the Annapolis area has been expressed, however, especially, in light of the overburdened facility at North Arundel.

The Annapolis Youth Services Bureau has been a long-term provider of services to the youth of the City of Annapolis. In existence for sixteen years and based in the Stanton Center, approximately 25% of its funding is provided by the City. The bureau has several satellite locations throughout the city and works with young people through various programs. Much of that work is in the area of drug and alcohol abuse, primarily in the area of prevention and counselling. Recently, counselling has been done within the City schools supplementing that already provided.

Although the Open Door, the Annapolis Youth Services Bureau, and all the organizations and facilities to be referred to later, provide excellent and much needed services, there is a universally recognized gap in one area. There is no locally convenient adolescent inpatient program. Nor are there any community centers in the Annapolis area to provide intensive follow-up services on an outpatient basis for adolescents. The Straight program maintains a facility in Springfield, Virginia, and others are available at opposite ends of the State. For families to be involved in these programs requires extensive commuting and when adolescents walk away from the facility local officials in other states and counties are difficult to deal with. When the adolescent returns to the community there is no support center that he or she can turn to in order to avoid being subjected to the same peer pressures that helped originate the problem. It is therefore, recommended that support be given to establishing such facilities in the Annapolis area.

Another gap recently filled is that of an inpatient drug facility for adults. Second Genesis, a long-term intensive program widely respected by the courts and professionals in the area of treatment and counselling, has been recently established in Crownsville. It is their expressed hope that adolescents may eventually become involved in the program.

At the public hearings held by the Task Force there was a recurring theme among those members of the public who had experienced substance abuse problems themselves or their families had. The question was, where do you go when you have a problem? Many citizens expressed the opinion that nothing was available or nothing was affordable. While the latter may be true as to some facilities, it is clear that there is a great deal available to the public in a wide variety of programs and organizations.

It appears that what may be lacking is a method for being referred to these services and a well-publicized way to learn that method. There is no general public awareness that anything exists as far as a central referral service in the area of drug and alcohol treatment and counselling. As has been seen with the drug hotline for law enforcement to be discussed later, a well-publicized number will be used by the public if they have easy access to it. There are existing hotlines that provide this type of referral service. An excellent example is the Anne Arundel County Sexual Assault Crisis Center and Anne Arundel County Hotline. That number, 280-1321, is manned 24 hours a day by trained staff that has information, not just relating to sexual assaults, but also to hundreds of counseling and treatment facilities working in the area of drug and alcohol abuse. Insufficient funding has prevented as wide an advertising of this line as its need would seem to require or as its operators would like. Many good ideas for dissemination of the number are still just that.

It is recommended that a drug and alcohol referral hotline be supported, the County Hotline appearing ideal, and that it be widely advertised and promoted in the City. Although there are others available, a common complaint is that the person seeking help never knows which is appropriate and is often passed from one number to another. This becomes frustrating and discouraging. One number should serve all needs.

Some of the methods suggested to the Task Force for advertising such hotlines are quite common sense and inexpensive. Mailing with electric, telephone and utilizing bills, bumper stickers on City vehicles, signs on City buses, stickers for parking meters, labels for telephones are just a few that have been suggested but are by no means exhaustive.

Listed below are many of the organizations and facilities that either offer or hope to offer services to the public in the Annapolis area. Also included is a brief description of what type of treatment and counselling services are offered. The listing is not meant to be exhaustive but rather to illustrate the variety and extent of help available.

AL ANON
ALATEEN
P.O. Box 763
Severna Park, Maryland 21146
(301) 766-1984

Help for family members with alcohol problems. Numerous meetings throughout the County. No dues or fees.

ALCOHOLICS ANONYMOUS
The Red House
169 Duke of Gloucester Street
Annapolis, Maryland 21401
(301) 268-5441

A twelve step program with recovering alcoholics helping other alcoholics to stay sober one day at a time. No dues or fees; everyone welcome. Approximately two hundred meetings per week in Anne Arundel County.

ANNAPOLIS MENTAL HEALTH CENTER
3 Harry S. Truman Parkway
Annapolis, Maryland 21401
(301) 224-7150

Counseling for addiction problems.

CHEMICALLY DEPENDENT ANONYMOUS
P.O. Box 4425
Annapolis, Maryland 21403
(301) 260-3009

Twelve step program of self-help from one chemically dependent person to another. Patterned after Alcoholics Anonymous; no dues or fees; numerous meetings in the Annapolis area.

CHRYSALIS HOUSE
8148 Jumpers Hole Road
Pasadena, Maryland 21122
(301) 544-1633

A ten bed, six-to-nine month residential facility for women in recovery from alcohol and drug addiction. Group and individual counseling. Individual treatment and employment assistance. Family counseling. Sliding scale for payment; minimum $6.64 per day.

DAMASCUS HOUSE
4203 Ritchie Highway
Baltimore, Maryland 21225
(301) 789-7446
647-8121

A halfway house for recovering male alcoholics offering a program with group counseling, individual counseling and family counseling. Sliding scale fees with no minimum.

FOCUS ON FAMILY
Monumental Title Building
650 Ritchie Highway
Severna Park, Maryland 21146
(301) 647-8121

Outpatient evaluation and counseling for County residents twenty-five years old or younger with drug and alcohol problems. Strong emphasis on family participation. Limited hours; sliding fee scale.

FORT GEORGE G. MEADE
ALCOHOL AND DRUG CONTROL OFFICE
4 1/2 Street-Building 2456
Fort Meade, Maryland 20755
(301) 677-2344

Program for active duty military personnel with alcohol and drug problems.

HARUNDALE YOUTH AND FAMILY
SERVICE CENTER, INC.
Harundale Mall-P.O. Box 1228
Glen Burnie, Maryland 21061
(301) 768-1110

A supportive group for persons twelve to nineteen years of age. Includes help in dealing with crises in the family group as well as addiction problems. No charge to clients.

HELPING HAND
82 Clay Street
Annapolis, Maryland 21401
(301) 268-9075

Emergency shelter, food, and other assistance for those in need.

HOPE HOUSE
P.O. Box 546
Crownsville, Maryland 21032
(301) 923-6700

A twenty-eight day residential drug and alcohol rehabilitation center for those over eighteen years of age. Program also includes treatment and education for family members as well as weekly aftercare help. Sliding fee scale

THE JACKSON CENTER
FINAN CENTER
P.O. Box 1722
Cumberland, Maryland 21502
(301) 777-2200

Forty bed residential program for those between thirteen and eighteen years of age with alcohol and drug problems. Individual and group counseling combined with school program. Local aftercare provided for teen and family. Sliding fee scale; insurance.

MEADOW RECOVERY CENTER
730 Maryland Route 3
Gambrills, Maryland 21054
(301) 923-6022

A twenty-eight day residential treatment and education program for alcohol and drug addition. Family program and after care are encouraged. Fee may be covered by insurance.

NEW BEGINNINGS AT WHITE OAK
Route 16, P.O. Box 56
Woolford, Maryland 21677
(301) 228-7000

A forty bed residential treatment program designed for those eighteen and under. Heavy emphasis on family cooperation and aftercare. Fee may be covered by insurance.

NORTH ARUNDEL HOSPITAL
CHEMICAL DEPENDENCY UNIT
301 Hospital Drive
Glen Burnie, Maryland 21061
(301) 787-4000

A seven day detoxification program that includes adolescents as well as adults. Close association with AA and NA. Fee is insurance, medicare, or self-pay.

OFFENDERS UTILIZING TREATMENT, INC.
Williams Center
7100 Oxon Hill Road
Oxon Hill, Maryland 20745
(301) 269-6741

Outpatient counseling for alcohol and drug addition. Family members also attend sessions. The emphasis is on persons who have been arrested and or convicted of crimes due to their substance abuse. Most counselors are former offenders that have turned their lives around. Sliding fee scale.

OPEN DOOR
62 Cathedral Street
Annapolis, Maryland 21401
(301) 280-1244

Outpatient treatment for alcohol and drug addiction including education and counseling. Urinanalysis and methodone program. Sliding fee scale.

PSYCHOLOGICAL SERVICES, INC.
111 Annapolis Avenue
Annapolis, Maryland 21401
(301) 263-8255
269-6977
261-1449

Outpatient treatment for alcohol and drug addition for adults and adolescents. Treatment and counseling addresses both the addiction and psychiatric problems. Insurance or self-pay fee.

RAFT HOUSE
P.O. Box 502
Crownsville, Maryland 21032
(301) 923-6081

Long-term residential facility offering education and counseling. Uses daily meetings of AA and NA. Sliding fee scale.

SAMARITAN HOUSE
2610 Greenbriar Lane
Annapolis, Maryland 21401
(301) 269-5605
269-6744

A halfway house for men addicted to drugs or alcohol. Provides counseling and assistance in daily living problems as well as a base for re-entering the job market. Sliding fee scale.

SECOND GENESIS
4720 Montgomery Lane
Bethesda, Maryland 20814
(301) 656-1545

Rehabilitation for adults with drug and alcohol problems in a residential setting. New facility just opened in Crownsville.

STRAIGHT, INC.
P.O. Box 791
5515 Backlick Road
Springfield, Virginia 22150
(703) 642-1980

Long-term self-paced treatment for teens with alcohol and drug problems. Forty beds available with individual and group counseling combined with school program. Local aftercare probided for teen and family. Sliding fee scale; insurance.

SCHOOLS

Our schools, both public and private, are important institutions which can and should play an important role in the area of drug use prevention and education. Being charged with a primary role in the education of our children, they are in an ideal position to teach the City's students the dangers of drug and alcohol abuse and ways in which they can resist peer pressure to experiment with dangreous substances.

It is recognized that drug education in the public schools has been somewhat of a controversial issue in the past. Some parents have expressed fear that teaching their children about drugs might not only educate them in their use, but also might engender a desire to experiment. It is clear to the Task Force that young people have already acquired a great deal of knowledge concerning drugs and their use from the streets and peer groups. Much of this knowledge is erroneous, dangerous, and is of such a nature as would tend to encourage experimentation.

The crisis is such that our younger generations will be exposed to and learn about drugs whether we like it or not. A recent survey of 4th graders by WEEKLY READER has indicated that 55 percent of them believe that the most effective way to prevent kids from using drugs and alcohol is to teach them the facts. That same survey of 68,000 4th graders revealed that 24 percent have been exposed to peer pressure to use crack or cocaine. For these reasons, it is imperative that the schools get to our children with an intensive program of education and guidance before the drug dealers do.

The Anne Arundel County Public Schools presently offer drug education principally through the science and social studies curriculums. The only mandatory or required curriculum is in the fifth grade. Other grades, both above and below the fifth grade, are provided with elective classes or instruction, which may or may not be provided for depending upon the perceptions of current needs. In short, the only time that a parent is assured that his or her child is receiving some form of drug education is in the fifth grade.

It has been widely commented to the Task Force that more must be done. Given that drug and alcohol abuse is beginning to bring our society to its knees, a strong up-to-date required curriculum throughout the educational process is clearly necessary and is recommended. If the answer to reversing the drug crisis is prevention, or reaching our children with the right message before they become involved, then the schools obviously have a large role to play.

If drug education in the schools is to be encouraged, there must be teachers, counselors, and administrators who are properly trained and prepared not only to teach these subjects, but to recognize and deal with symptoms which they observe among the students. These subjects should be taught and dealt with not as abstract ideas, such as math or chemistry, but with the real understanding that there is a great likelihood a student hearing that lecture has a real problem that should be dealt with.

Public school teachers in Anne Arundel County, for the most part, have not received inservice training in drug education and prevention since 1981. Patterns of drug and alcohol use and abuse change faster than that. Crack is a drug not known in Annapolis three to five years ago. Loveboat, a combination of PCP and marijuana, is also a recent development. Very few things change as rapidly as the drug culture. Fads in drug use and distribution come and go. Polydrug use is becoming much more prevalent with the attendant problem in recognizing symptoms.

More intensive and frequent training of school personnel at all levels is recommended. Again, this is a need expressed to the Task Force on many occasions. More faculty meetings should be devoted to discussing the issue. More frequent required and paid in-service training of teachers should be devoted to addressing the problem. The schools are the only forum in which adolescents are required to receive certain instruction. Frequent drug and alcohol education presented by well-trained school personnel should be of primary emphasis. All the other instruction in all the other subjects is wasted if the student goes on to a life of addiction.

It has also been suggested to the Task Force that the school curriculum relating to health issues and life skills needs to be strengthened, especially in the area of drug and alcohol use. Some have been described as outdated and inadequate with the third and fourth grade appearing weakest. The Task Force has been shown several very timely and innovative curriculums available in the area of drug and alcohol education and many more are presently being developed. It has been suggested that these new expanded curriculums should be presented in a seventh period format and placed on an equal level with all the other subjects requiring successful completion for graduation. Such well-developed and presented classes are recommended to ensure that the student is prepared to cope with more in life than reading, writing, and arithmetic.

All of the above discussion relating to what the schools might do does not mean that parents should not become involved. Through parent teacher associations and parent education programs, schools and parents should work together. Parents still carry the primary obligation in teaching life skills.

To deal with the student caught using drugs or alcohol in the schools, the Alternative Drug Program was adopted in 1980. This is a mandatory program for every student caught with drugs or alcohol on school property. After a five day suspension, the student is required to enroll. Failure to attend or being caught a second time results in expulsion from the public school system.

The program requires eight, two hour, evening sessions relating to drug education over a ten month period. Additional instruction is also provided for. There is a voluntary program for the parents of the students in which almost all parents become involved. The students in the Alternative Drug Program are allowed to engage in extracurricular activities, but not if they interfere with the drug education classes.

The program is recognized by the Task Force and widely throughout the nation as a model program in addressing the drug problem in the schools. The White House Conference for a Drug Free America, in commenting on the Anne Arundel County Alternative Drug Program, stated that "strong no-use policies have helped this district reduce a serious drug problem." It is recommended that this program continue to receive the support of the County, City, and community.

Those students caught using drugs off school property often become involved in supervision by the Department of Juvenile Services. The Alternative Drug Program would be an ideal condition of probation for those juveniles.

There was some discussion by the Task Force as to whether students in the program should be allowed to participate in extracurricular activities such as sports, etc. It was the consensus, however, that to deprive students, who were successfully pursuing the program, from engaging in these activities might be discouraging or counterproductive.

Some concern was also expressed over what the suspended student is doing during the five day suspension after being caught with drugs. Suspension is a recognized and traditional punishment for students violating school rules. In these cases, especially in the day of working parents, such suspensions may be viewed as a short vacation in which continued use might be inevitable. An in-school suspension program removed from the student body, perhaps relating to drug education, might be more appropriate.

The Alternative Drug Program, as well as the new no smoking policy (which may have removed a cover for marijuana use) have been successful in pushing a good portion of drug and alcohol use off of school property. In addition, it is important that all students receive frequent mandatory drug and alcohol education by well-trained instructors. Only in that manner can we be sure that the Alternative Drug Program teaches a greater lesson than "don't get caught on school property."

A review of the Survey on Drug Education in the Anne Arundel County Schools done in 1985 and 1988 present a very sobering and troubling picture of student attitudes, knowledge, and use of drugs, alcohol and tobacco. Given the inexactitudes of any survey of this type, especially involving adolescents, it is still clear that there is a long way to go. It is also clear that these surveys are an invaluable tool in evaluating the effectiveness of curriculums and programs. They also reveal trends that may require efforts in new directions. It is recommended that these surveys continue to be undertaken on a regular basis and that the results be made available to the City, County and public in a timely manner.

Although most of the above discussion deals with the public schools, the students in private schools are at the same risk. It is hard to imagine, given the extent and pervasiveness of the problem, where a child could be placed, either in or out of school, that he or she would not be confronted with peers who are users of drugs and or alcohol.

LAW ENFORCEMENT

Law enforcement is an essential ingredient in the war on drugs. It is, in fact, the front line in the war against the dealer in drugs who attempts to make vast profits in the misery of others and the destruction of our society.

Law enforcement also plays an important role in the use of drugs. When a user is arrested for possession, it often serves as an important intervention to make that individual aware of the sanctions he faces in addition to health problems, or force him into treatment and counselling as part of court imposed sanctions.

It is universally recognized that law enforcement cannot solve the drug problem alone. Without the efforts in the area of prevention, education, treatment and counselling to reduce the demand for drugs, there will always be other suppliers to take the place of those incarcerated. In fact, it appears that law enforcement is just barely holding its own in this area. There seems to be no end to the number of people who are ready, willing and able to buy and sell drugs.

To meet what was perceived to be a growing problem in the City of Annapolis, a joint city-county police task force was formed in January of 1986. This task force, made up of detectives from the Annapolis and Anne Arundel County Police Departments, was intended to attack those who deal drugs in Annapolis at every level. Since that time, the City, County, and State police have also undertaken significant independent investigations of drug dealing in Annapolis. As a result, the felony prosecutions of those distributing drugs has risen well over one hundred percent. Although drug use is continuing at a high level, these statistics do not represent as much of an increase in drug distribution as they do an infiltration by police of drug dealing organizations that have existed for some time, several for many years. The more enforcement, the more arrests.

Those charged cover a broad spectrum of individuals and involvement. Among them are businessmen, street dealers, multikilo dealers, school bus drivers, out-of-state importers, and juveniles to name just a few. Many have been arrested a second time for distribution before they have gone to trial on the first charge.

It appears that the law enforcement is at or near a maximum effort in the Annapolis area. An essential part of that effort has been the City-County Task Force. Although some concern has been expressed that the County police resources might also be stretched too thin to continue this type of effort, there is no real indication that is the case at the present time. It is recommended that the Task Force be continued at the present enforcement levels or increased if possible.

Attention and emphasis in law enforcement should be placed on all level dealers in all sections of the community. White collar or high level traffickers may be more difficult to catch but they should be pursued just as vigorously, or more so, than the street peddler of small quantities. A credible law enforcement effort must be an impartial effort.

The police are only part of the law enforcement effort relating to drugs. The entire criminal justice system is involved. There must be vigorous prosection of drug dealers, stiff sentences and a place to put those incarcerated.

A consistent and recurring criticism raised at the public hearings was the lenient sentences given to drug dealers by the courts. Many felt the courts are just a revolving door for these individuals and they know it. It is clear that although drug dealers are criminals, they are not for the most part stupid. If one can engage in an illegal business that reaps huge profits and know at the outset that getting caught will only entail a period of probation, then there really is no deterrence.

It is true that judges have a very difficult task in resolving a case. The interest of the individual and that of society must be carefully balanced. But when that society continually comes out the loser and is slowly being destroyed by these individuals, there soon will be nothing but the rights of the individual left and that is anarchy.

As to the argument that judges can't incarcerate drug dealers as the prison system is full, the answer must be sentence them anyway. Telling a drug dealer that he won't be sentenced to the prison system because it is full of people who have committed crimes to get drugs or because of drugs, is tantamount to a reward for their behavior. More facilities for incarceration can and will be built.

The perception that drug offences are victimless crimes and should be treated as violations of health regulations overlooks the fact that the overwhelming majority of all other crime is drug related. It also overlooks the real threat that drugs are to the very core of our civilization.

The fact that this perception still exists in elements of the criminal justice system is borne out by a recent policy adopted for the County District Court Commissioners. As judicial officers, they decide whether arrest warrants should be issued in criminal cases. In the past, warrants for the arrest of drug dealers have always been issued when requested by the police. Under the new policy, in many cases, only summonses are being issued for these defendants to appear in court at a certain time on a certain date.

The reason for the new policy has been expressed as the rise in the number of cases and the lack of seriousness of those particular distribution cases. No bond is required, no fingerprinting is possible to identify the individual, and there is nothing to prevent flight. Again, this sends the wrong message to the community, and drug distributors - you no longer need even face arrest. This practice should cease.

The Maryland Legislature, in response to the growing public outcry for stiffer treatment of convicted drug traffickers, has adopted mandatory sentences upon the second conviction for drug dealing. This legislation, depending upon the drug, requires a minimum number of years to be imposed which cannot be suspended nor the defendant paroled. This appears to be an essential ingredient in the war on drugs if it is to have any teeth. It is also recommended that mandatory sentences should be adopted and imposed upon anyone who uses a juvenile as a go-between for drug transactions or as part of a drug conspiracy. This appears to be a growing practice in the Annapolis area.

Legislation is also required in the area of seizing the profits and property of convicted drug peddlers. At the present time, the State may only forfeit and keep money and vehicles that can be proven to be the proceeds of or to have been used in drug distribution. Homes, buildings, and real estate are immune. Needless to say, vast wealth from illegal drug profits can and are being hidden behind property deeds. Loss of such property is probably a greater penalty to such individuals than whatever little incarceration they receive and should be made another weapon in the arsenal in the war on drugs.

Nor should those convicted of felony drug charges remain anonymous in the community. In many cases, their illegal activities continue. Early in our hearings, we recommended that local media should publish the names and addresses of those convicted of felony drug cases and that practice is now in effect. People should know who is living in their community. Signs of drug dealing activity are easy to spot. An aware neighborhood is a safer neighborhood. The media provides a valuable watchdog role in informing the public of who is doing what, not only by covering criminal activity, but also the efforts to combat it.

Another complaint by many in public and subsidized housing is that heads of households are being allowed to remain in that housing after they, or someone living there, has been convicted of drug distribution. Under Federal guidelines, such individuals may be denied housing. Although some have been evicted in the past, there has been no consistency which leads to even more serious complaints of impartiality. Failure to take action to deny housing, or acting in an inconsistent manner, sends the wrong message to those households. It provides no incentive for those who need such housing to deny access to persons who want to turn their apartments into crack houses, safe houses, storage centers, or distribution points. Drug pushers should have no guaranteed haven within publicly supported housing.

Another consensus gleaned from the public hearings is that the community is clearly in favor of foot patrols by the Annapolis City Police. This brings law enforcement to a personal level and if anything it discourages the supermarket atmosphere of street dealing in drugs that has been experienced in many communities.

One criticism raised at the hearings has been that a foot patrol in one community simply drives many dealers to another that does not have a foot patrol. It is recommended that foot patrols be continued and placed in all communities that are at high risk.

Whether additional foot patrols would require additional manpower within the City Police Department is not clear. Although additional officers have recently been authorized, there is a perception that the force is below the recommended number of police per thousand citizens. This might be especially so in Annapolis which draws many thousands of tourists each year, with their attendant law enforcement problems.

One less costly recommendation than personnel increases is a needed modification to existing radio equipment to allow foot patrol officers and all personnel with radios to communicate with each other directly rather than going through a dispatcher which is the present arrangment.

Another recommendation, which should cost nothing or very little, would be stepped up public relations activities by the law enforcement agencies working in the City. The State, County, and City police, as well as the State's Attorney's Office, could quite easily provide information, literature, or speakers to the public and schools relating to the legal aspects of illicit drug use. There are many misconceptions held by citizens as to exactly what the laws, rights, and penalties are in this area.

Police can't wait for a drug deal to take place and then investigate and make arrests. They must go out and find the dealer and attempt to catch him with the drugs or arrange a sale to an undercover officer. To do that they need information. Much of that information can come from law abiding citizens who see suspicious activity or have heard of who is selling what to whom. For that reason, an effective drug hotline is essential. Just as importantly, that number must be well-publicized and be recognized as the number to call similar to the 911 emergency number.

The means of advertising the number, as discussed in the section dealing with treatment and counselling are varied and not expensive. Since discussions at the public hearings, local media have began publishing a drug hotline number.

That number, 1-800-752-DRUG, is the number recommended as the most effective. A call on that line goes directly to the offices of the City-County Task Force. That information is received by the detectives working in Annapolis on a daily basis investigating drug cases. A tip gets directly to the people that can make the most use of it in the quickest time.

One drawback of that line is that the call is presently answered by a recording. Many citizens have indicated that they would prefer to talk to someone personally. A personal conversation might also elicit additional information, such as who, what, when, and where. The citizen could also be advised of what additional information might be helpful and the type of police response that can be expected. Investigations in drug cases often take a considerable amount of time, a fact which the caller should be made aware of. The community will only use such a hotline if they have confidence in it. It is therefore recommended that when possble, the hotline be manned by someone other than a recording.

Examples of the effectiveness of a well-publicized hotline are the recent raids on three apartments in the Boston Heights area which resulted in the seizure of large quantities of cocaine and the arrest of several individuals. After an intense effort to distribute the hotline in that community, literally door-to-door, calls were received relating to the individuals and apartments involved and helped provide the basis for the arrests and seizures.

Consideration was also given to making cash awards to those providing effective information. This is a time honored and well-recognized method of rewarding those who assist in apprehending criminals. The nature of the drug dealing community, however, creates a problem. Many dealers are in competition with each other as in any business. It is not unusual for one dealer to turn in, set up or inform on another in order to gain a larger share of the market. A cash reward for such information may, in many cases, be putting money into the pocket of another drug dealer. If a method could be devised to avoid this result, the concept could have merit and would be worth pursuing. Crime Stoppers, (301) 276-8888, presently provides cash awards for anonymous tips. Those awards are privately funded.

PREVENTION

The crisis in drug abuse facing the City of Annapolis will only be alleviated when the demand for illicit substances is reduced or eliminated. If the interest in experimenting with or use of drugs is reduced there will be a corresponding reduction in the need for drug distributors, police to catch them, or jails to put them in. The need for expensive rehabilitation centers and counselling groups will likewise be reduced. In short, the war on drugs will only be won when the attitude of our citizens becomes one of simple intolerance for the use of drugs or anyone that does. Because illegal drugs exist does not mean that they will necessarily be abused. In fact, many of the nations who are primarily responsible for importing illegal drugs into this nation have populations that don't use drugs.

It is widely recognized that the primary way to decrease demand is in the area of prevention. The attitudes of our youth should be such that when they are first confronted with the use of drugs, they can and will effectively say no. That attitude can best be instilled through the family and the community. It must come in the form of adult role models that youth will want to emulate. It seems far cheaper and more effective to get to our youth before the drugs do than try to deal with the problem after they have become criminals and addicts.

The effort in the area of prevention is a difficult one. That effort must come from within the community itself. It must be done by the family, individuals, and groups of individuals banding together to get the message across. No amount of money, police, treatment centers, or counsellors can accomplish this goal. It requires a fundamental change in attitudes about drug use which is then instilled in the youth of the next generation. We are beginning to see this change in attitude. The citizens that were heard at the public hearings, as well as the citizens of the nation, are demanding that something be done.

Much is already being done in the area of prevention and working with youth but much more can be done. For Kids Sake, Annapolis Live Free Council, Diamonds in the Rough and other public and privately sponsored programs and groups are effectively getting the message across to our children and youth. Others have yet to come to the fore. Recreation and Parks should have a drug education and prevention program as part of its summer curriculum. The Chamber of Commerce, corporations, civic organizations, churches, and businesses to name just a few could do much with very little effort.

Prevention is the area in which the City of Annapolis could act as a catalyst and in which it is recommended that the City devote additional resources. This is the area where effective programs can have the most impact for the least cost. Under appropriate guidelines, any group or organization that is interested in pursuing a project or event which addresses the issue of prevention should receive support from the City, either in grants to clear financial obstacles or in providing advice and guidance in pursuing their goals. The concept and execution of the event or project would be solely the responsibility of the interested group or organization.

An excellent model is the Planning Action Committee concept which was initiated by the County Drug and Alcohol Program. These committees are made up of residents of various communities that want to take some action in the area of prevention. On August 21, 1988, the first annual Annapolis Says No To Drugs Day was held. The event was initiated and undertaken by the City and several Planning Action Committees. A rally was held at Weems-Whelan field where food was served and entertainment and speakers were provided. The message throughout was say no to drugs and the event was well-attended. More imporantly, there were numbers of youth of all ages present. For many, this may have been their first exposure to the concept that drug use is something that does not have to be accepted. There were many respected adults from those youth's communities saying drugs are wrong. These are the types of activities that should be fostered and promoted.

To facilitate this effort it is recommended that a drug advisory council be established for the City of Annapolis. This council would serve two purposes. The first would be to consider and evaluate applications requesting grants for activities in the area of prevention and education. Recommendations would then be made to the City Government for dispersal of funds to meritorous activities. To facilitate and expedite the consideration of these applications no more than three designated members of the Council would be required to consider and evaluate the requests. The second purpose, which will be discussed later, would be to provide a continuing and long-term monitoring and evaluation of the overall war on drugs in the City of Annapolis.

A citizen group that wishes to organize, sponsor, or promote an activity in the area of prevention or education often spends a good portion of it's time and energy attempting to raise the necessary funds to sponsor and promote the activity. Many fail for lack of financial support, which in many cases may be minimal. Community groups facing that dilemma should be encouraged to make informal applications to the drug advisory council which would then evaluate and make recommendations for a monetary grant. An evaluation of the results or outcome of the event or activity would be made by the council.

A position within the Mayor's office is also needed to help advise these groups and organizations and help facilitate their progress toward their goals. For many of the members of these groups the concept of advertising, promotion, distribution and accounting of funds, and other management concepts may be new. Such an individual could also encourage long existing social, fraternal, and religious organizations, as well as businesses and churches, to become involved in the prevention effort. These groups and organizations have vast experience in organizational, fundraising, and managerial skills. If even a small fraction of the talent in these organizations were devoted to educating our youth and instilling new attitudes toward the dangers of substance abuse, the effect could be substantial.

The facilitator would not be responsible for organizing any event or activity, but providing advice and guidance. If the demand for drugs is to be reduced, it can only be done by such citizen groups acting within the community to alter the attitudes of families and youth toward drug use. Only by such grass-roots activities can the war on drugs be won.

The person acting in this position would also work with the Council in reviewing the applications and making recommendations for expenditures, as well as seek additional sources for funding such activities. Federal and State resources and grants are presently available and more will soon be coming on line, especially in the area of prevention.

The drug advisory council could also provide an additional service to the City Government. It could act as a long-term watchdog over all of the efforts in the City to fight the war on drugs. In annual, biannual or quarterly reports, it could evaluate and reevaluate the efforts in the areas of law enforcement, treatment, counselling, education, and prevention. These reports to the City would assess programs and make recommendations where deemed appropriate. The problem of substance abuse is so vast and complex that an advisory group to monitor and evaluate the progress in combating it is a clear necessity.

The council should be composed of representatives of all factions involved in dealing with substance abuse. It should be composed of individuals working in the areas of law enforcement, health care, counselling, education, and prevention. Representatives from the communities, businesses, and the churches should also serve, as well as a student representative. The interaction of all these view points is necessary to present an overall picture of where we stand in the war and how strategy should be developed and executed to further its progress.

During discussions of the proposed activities of such a council in the area of prevention, a consistent cautionary flag has been raised. It has been pointed out to the Task Force that care should be taken to not try and reinvent the wheel. The Anne Arundel County Executives Drug and Alcohol Program has in effect an active program in the City that is ongoing. To allow the City and County programs to overlap or conflict in this area would be unfortunate. One of the priorities of the drug advisory council must be to ensure that there is full cooperation and coordination between City activities and those of the County. Addressing the problem of preventing the use of drugs is difficult enough without adding the problems encountered with intergovernmental or agency conflicts.

RECOMMENDATIONS

The recommendations of the Task Force have been set forth during the review of the various aspects of dealing with substance abuse. The following is a brief synopsis of those which, if implemented, might have a substantial impact on the outcome of that struggle:

1. Open Door should maintain its facilities within the City;

2. Anne Arundel General Hospital should establish a detoxification unit;

3. There is a need for an adolescent inpatient facility as well as an extensive follow-up outpatient service.

4. The 24-hour Anne Arundel County Hotline for treatment, counseling, and crisis referrals should be supported and extensively advertised.

5. Schools must provide more required drug and alcohol education. That education should be presented by better trained teachers using up-to-date curriculums. Periodic surveys of trends in the schools should be continued and the results published.

6. The City-County Police Drug Task Force should be continued and foot patrols maintained and expanded.

7. Everyone charged with a felony drug violation should be arrested. Laws relating to the use of minors in drug deals and the forfeiture of real property should be adopted.

8. Convicted drug dealers must be removed from public and subsidized housing.

9. Law enforcement agencies should help educate the public as to the laws relating to controlled dangerous substances.

10. The most effective police hotline, 1-800-752-DRUG, should be answered personally rather than by a recording and the number should be widely advertised.

11. Cash awards could be given to those providing effective information on drug dealing if it could be assured the money wasn't going to other dealers.

12. All sections of the community, public and private, must become involved in activities relating to prevention and education, the most important factor in the war on drugs.

13. The City should create a drug advisory council and a position within the Mayor's Office to supervise the expenditure of funds for prevention and to monitor, in the long-term, the efforts in law enforcement, treatment, counselling, education, and prevention.

14. The City and County should work closely together in addressing the substance abuse problem to avoid any conflict or overlapping in effort.

SUMMARY

It is hoped these recommendations address the broad objectives that were established for consideration by the Task Force. They are directed not only to the City Government, but to all elements of our society that must deal with the problem of substance abuse. Government cannot reverse the tide nor can any private group or organization; only the people can. It is from the citizens of Annapolis that the Task Force has received its guidance and it is to them that this report is addressed.

All elements of the community involved in coping with the problems of drug and alcohol abuse have been consulted. It is from their broad consensus as to how to deal with the problem that the consensus of the Task Force was formed. Although there may be some differences of opinion in the tactical aspects of the struggle, there is no disagreement as to the long-term strategic goal - the reestablishment of a society free of drug abuse.

Task Forces come and go and many times the problems they were created to deal with remain or resolve themselves. The crisis of drug abuse now facing the City of Annapolis and the nation will not resolve itself nor can we afford to allow it to continue unabated. It may take many years to return to where we started but there is a sense within the community that the turning point is near. Attitudes of condoning, accepting, or simply ignoring drug abuse are swinging to ones of intolerance of drugs. That attitude of no tolerance, zero tolerance, or however one wishes to describe it, is one that everyone should have, and hopefully, in the not to far distant future, will. As the Task Force was told many times, something must be done and it must be done now.

The following individuals and organizations have submitted letters and documents to the Select Committee for their consideration and review. Due to the overwhelming volume of correspondence generated by this hearing we cannot print all of the correspondence and therefore we will list the names of those persons making submissions.

Florence Katz
    Concerned Citizen
    Alexandria, Virginia
W. Michael Trout
    Concerned Citizen
    Pt. Orange, Florida
Herbert Berger, M.D.
    Concerned Citizen
    Staten Island, New York
James E. Dwyer
    Journalist/Writer
    Douglas, Arizona
Edward M. Brecher
    Concerned Citizen
    West Cornwall, Connecticut
Jeffrey A. Schaler, M.Ed.
    Concerned Citizen
    Silver Spring, Maryland
Richard E. Carney, Ph.D.
    Executive Vice President
    Timao Foundation for
      Research and Development
    San Diego. California
Anthony Cicoria
    Vice Chairman, County Council
    Prince George's County, Maryland
Gabriel G. Nahas, M.D., Ph.D.
    Professor of Anesthesiology
    Columbia University
    New York, New York
Police Executive Research Forum
    Washington, D.C.
Dr. Peter A. Krakowiak, Ph.D.
    Doctoral Level Scientist
    Glenmoore, Pennsylvania
Brown & Associates, Inc.
    Washington, D.C.
Frederick W. Ford
    Attorney
    Falls Church, VA
Douglas H. Palmer
    President, Board of Freeholders
    County of Mercer
    Trenton, New Jersey
Kevin D. Teasley
    Public Affairs Officer
    Reason Foundation
    Santa Monica, California

The following constituents of Congressman Kweisi Mfume (D-MD) made submissions which could not be printed due to space limitations.

Ben Prestbury
    Concerned Citizen
    Baltimore, Maryland
A. Robert Kaufman
    Concerned Citizen
    Baltimore, Maryland
Ms. Margaret Zipp
    Concerned Citizen
    Baltimore, Maryland
Carl O. Snowden
    Councilmember
    City of Annapolis
    Annapolis, Maryland
Dr. Charles W. Griffin
    President
    West Arlington Improvement Association
    Baltimore, Maryland
Flossie Dedmond
    Concerned Citizen
    Baltimore, Maryland
Saundra E. Banks
    Clerk
    Circuit Court for Baltimore City
    Baltimore, Maryland
Paula C. Hollinger
    State Senator
    Senate of Maryland
    Annapolis, Maryland
Dr. Harold A. Carter
    Minister
    New Shiloh Baptist Church
    Baltimore, Maryland
Madeline W. Murphy
    Concerned Citizen
    Baltimore, Maryland
Blanche W. Pettiford
    Concerned Citizen
    Baltimore, Maryland
Mary Carter Smith
    Concerned Citizen
    Baltimore, Maryland
Stephen E. Bruns
    Concerned Citizen
    Baltimore, Maryland
Joseph B. Church
    Concerned Citizen
    Baltimore, Maryland
Howard Aylesworth, II
    Concerned Citizen
    Baltimore, Maryland

Rev. Dr. Leroy Fitts
    Pastor
    First Baptist Church
    Baltimore, Maryland
Karen K. Wilson
    Concerned Citizen
    Baltimore, Maryland
McNeal Brockington
    The Hub, Inc.
    Baltimore, Maryland
Lawrence W. Armstrong
    Concerned Citizen
    Baltimore, Maryland
Beatrice Bennett
    Concerned Citizen
    Baltimore, Maryland
Gwendolyn B. Hagood, C.H.E.
    Extension Home Economist
    Maryland Association of
      Extension Home Economists
Christine Crystal Clear Fulwood
    Concerned Citizen
    Baltimore, Maryland

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